MACON COUNTY GENERAL HOSPITAL
P. O. BOX 378
LAFAYETTE, TENNESSEE 37083

PHONE 615-666-2147

AFFIDAVIT OF CUSTODIAN OF MEDICAL RECORDS

I, Christel Carter, RHIT, am the duly authorized Custodian of Medical Records for Macon County General Hospital under the laws of the State of Tennessee and have authority to certify said Medical Records, and

I further certify that the enclosed copy of Medical Records pertain to (patient) Pamela J. Cherry for dates of service: 5/30/2011 and 5/31/2011; and attached to this Affidavit is a true copy of the original medical records, and

Said Medical Records were created and maintained by the personnel of the hospital, staff physicians, or persons acting under the control of either the hospital personnel or staff physicians during the ordinary course of business and recorded at or near the time of the act, condition, or event reported therein, and

The cost to furnish the copies of these medical records is based on the usual charges of the hospital in accordance with T.C.A. 68-11-304.

Christel Carter, RHIT
Christel Carter, RHIT
Director, Health Information Management

6-15-12
Date

Subscribed and sworn to before me, a Notary Public, on this 15th day of June, 2012.

Notary Public, State of Tennessee

My Commission expires: 3-18-2014

TAMMY ... STATE OF TENNESSEE NOTARY PUBLIC ... COUNTY OF MACON ... ORT

EXHIBIT
H

134017

MRSA:
VRE:

MACON COUNTY GENERAL HOSPITAL

204 Medical Drive • Lafayette, Tennessee 37083 • (615) 666-2147

Advance Directive: N

REGISTRATION ADMISSION

PATIENT ACCOUNT NO.	MEDICAL RECORD NO.
1032224	000028132

PATIENT (Name, Address, Phone)	BIRTH DATE	AGE	SEX	RACE	PRIM. LANGUAGE	SOCIAL SECURITY NO.
CHERRY PAMELA J 1152 FLETCHER AVENUE INDIANAPOLIS IN 46203 COUNTY: MARION PHONE: (317)683-4716	[redacted]	58	F	W		[redacted]

MAR. STATUS	REL	FC	ADMITTED BY	HIPAA NM	HIPAA RIM	HIPAA REL	HIPAA COPY
M	Q	B	EAU	Y	Y	Y	Y

ADMISSION DATE & TIME	DISCHARGE DATE & TIME	SERVICE	ROOM / BED NO.
05/30/11 19:15		EMR	/

PATIENT EMPLOYER (Name, Address, Phone, Occ)	EMERGENCY CONTACT 1 (Name, Address, Phone, Rel)	EMERGENCY CONTACT 2 (Name, Address, Phone, Rel)
FARM BUREAU PHONE: OCC:	CHERRY DAVID PHONE: (317)683-4716 REL: SPOUSE	REL:

GUARANTOR (Name, Address, Phone, Rel)	GUARANTOR EMPLOYER (Name, Address, Phone)	ATTENDING PHYSICIAN (Name, Number)
CHERRY PAMELA J 1152 FLETCHER AVENUE INDIANAPOLIS IN 46203 PHONE: (317)683-4716 SSN: [redacted] REL: SELF	FARM BUREAU PHONE:	ILIA HANNA 4950

ADMITTING PHYSICIAN (Name, Number)	REFERRING PHYSICIAN (Name, Number)
ILIA HANNA 4950	0

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
ANTHEM ONE CAMERON HILL CIRCLE SUITE 0002 CHATTANOOGA TN 374020000 POLICY# [redacted] GROUP #: [redacted] GRP NAME: BC AUTH#: CHERRY PAMELA J SEX: F RELATION: 18	POLICY# GROUP #: GRP NAME: AUTH#: SEX: RELATION:	POLICY# GROUP #: GRP NAME: AUTH#: SEX: RELATION:

CHIEF COMPLAINT / ADMITTING DIAGNOSIS

COMMENTS

05/30/11 19:29
Current System Date and Time

MC1000/112409

MCGH0002

Macon County General Hospital
Lafayette, Tennessee

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/30/11 RM/BED: /
ATT: ILIA HANNA
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032224

EMERGENCY DEPARTMENT

ADVANCE DIRECTIVES

☐ None known _____
☐ POA for Healthcare? Name: _____ Phone: _____
☐ Living Will? Content if copy not available _____

PHYSICIAN ORDERS

Salvia Lozenge
NS 500 cc IV Bolus X 1
NTG. 0.4 mg S.L
Toradol 30 mg IV X 1
DC Rocephin
Flu & PCV

Physician Signature

Return to ER within 72 hours?
☐ Yes ☐ No

Medical Record Obtained for Review?
☐ Yes ☐ No

Laboratory Orders:
☐ Amylase
☐ Blood C&S x 2
☑ ~~BMP~~ CMP
☐ BNP
☐ CBC with Diff
☑ CK-MB
☐ CPK
☐ Digoxin Level
☐ Flu Screen
☐ Free T-4
☐ Lipase
☑ Magnesium
☐ Myoglobin
☐ PT
☐ PTT
☐ RSV
☐ Sputum C&S
☐ Strep Screen
☑ Troponin
☐ TSH
☐ Urinalysis
☐ Urine C&S

Radiology Orders:
☐ CXR PA & Lat
☐ CXR Portable

Other Orders:
☐ ABG
☐ Crisis Protocol
☑ EKG
☐ Jet Neb
☐ Old Chart

134017

Unacceptable Abbreviations: U; IU; QD; QOD; MS; MSO_4; $MgSO_4$; lack of leading zero; presence of trailing zero

ER#134017

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33 Macon County General Hospital

EMERGENCY PHYSICIAN RECORD

•Chest Pain•

PQRI – Physician Quality Reporting Initiative

DATE 5-29-11 TIME: 1920 ☐ on arrival ROOM: 1

__ EMS Arrival __ EMS treatments ordered

HISTORIAN: patient spouse paramedics

__HX / __EXAM LIMITED BY:

TRANSFER FROM: ☐ see transfer record

TREATMENT PTA: by patient paramedics EDP PCP

lasix nitroglycerin O_2 albuterol neb tx aspirin

HPI

chief complaint: chest pain / discomfort

From head ? to left,

onset / duration: ___ hrs / days ago

__ time of onset between 4 AM and 7 AM

timing: sudden gradual onset | constant "waxing & waning"

still present better worse | intermittent episodes lasting

gone now lasted | persistent / worse since

context: onset during: sleep rest emotional upset activity/exertion

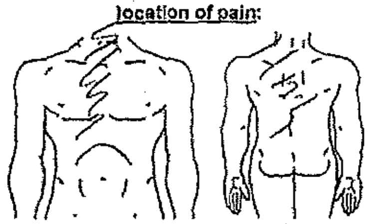
Stayed under the sun all day

severity: max: mild moderate severe (1/10)

currently: mild moderate severe (1/10) gone

quality:
pressure
tightness
indigestion
burning
dull
aching
sharp
stabbing
like prior MI

location of pain:



radiation (show radiation: ⟶)

radiation: __ none diagrammed above

arm / shoulder / back / neck / jaw

associated symptoms:
nausea / vomiting
sweating
shortness of breath
hurts to breathe
palpitations
cough blood / sputum
weakness
dizziness

worsened by: __ nothing
deep breaths exertion
movement change in position

relieved by: __ nothing
sitting up rest antacids
nitroglycerin O_2 aspirin

Similar symptoms previously - angina

Recently seen / treated by doctor / hospitalized

ER# ___ CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/30/11 RM/BED: /
PCP: MARGARET MAXWEL #: 0
Name: ___ ATT: ILIA HANNA #: 4950
MR #: 000028132 PAT #: 1032224

ROS

CONST
recent illness
fever / chills
recent injury

MS / LYMPH
neck / back pain
calf pain
ankle swelling

GI / GU
abdominal pain
black stools
problems urinating
LNMP preg post-menop

EYES / ENT
problem with vision
sore throat

SKIN / ENDO
rash
recent weight change

NEURO / PSYCH
headache
fainting
anxiety
depression
☐ all systems neg except as marked

• CVS / RESP / GI / NEURO components also addressed in HPI

PAST HX

hypertension
diabetes Type I Type 2
diet / oral / insulin
hyperlipidemia
cardiac disease
AMI angina CHF A-Fib
DVT / PE risk factors: cast cancer
recent surgery leg swelling bedridden
paralysis prior DVT/PE
TAD / AAA risk factors:
pregnancy connective tissue dz
Marfan's Ehlers-Danlos

CVA / TIA deficit
GI disease
GERD peptic ulcer GI bleed
gall stones hepatitis pancreatitis
immunocompromise
HIV malignancy steroids transplant
kidney disease / dialysis
lung disease
asthma COPD pneumothorax

__ old records ordered / summary:

Surgeries / Procedures __ none
cardiac bypass
cardiac cath / stent
pacemaker / ICD
stress test
CT / MRI / ECHO

cholecystectomy
appendectomy
hysterectomy
dental work recent

Immunizations: influenza / pneumovax UTD / referred to PCP

Medications __ none see nurses note
aspirin / β-blocker (within 24 h) coumadin
clopidogrel BCPs

Allergies NKDA
see nurses note

SOCIAL HX smoker ___ ppd drugs (cocaine / IV)
alcohol (recent / heavy / occasional) occupation
living situation: alone at home in nursing home

FAMILY HX CAD (under 55 / over 55) DVT/PE AAA/TAD

* = ACS cardiac risk factors chest pain fail safes

MCGH0004

Pt. Name_____ Date_____

☐ Nursing Assessment Reviewed ☑ Vitals Reviewed _____

PHYSICAL EXAM

P Q R I **General Appearance**
__no acute distress __mild / moderate / severe distress_____
__alert __anxious / lethargic_____

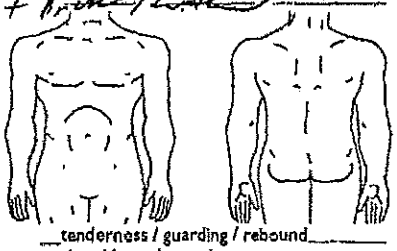
EENT
__PERRL __post-surgical pupillary defect (R / L)_____
__eyes nml inspection __scleral icterus / pale conjunctivae_____
__EOM palsy / anisocoria_____
__ENT nml inspection __pharyngeal erythema_____
__pharynx nml __abnml TM / hearing deficit_____

NECK
__nml inspection __JVD present_____
__no carotid bruit __lymphadenopathy*_____
__subcutaneous emphysema_____

RESPIRATORY
__no resp. distress __see diagram_____
__chest non-tender __respiratory distress_____
__nml breath sounds __manifests distinct pain on movement R / L arm trunk_____
__splinting / decr air mvmnt_____
__wheezes / rales* / rhonchi_____

CVS
__reg. rate & rhythm __irregularly irregular rhythm_____
__no murmur __extrasystoles (occasional / frequent)_____
__no gallop __tachycardia / bradycardia_____
__no friction rub __friction rub / Hamman's crunch_____
__pulses full / equal __gallop (S3 / S4)*_____
__murmur grade__/6 sys / dias_____
__decreased pulse(s)_____
R / L radial__ fem__ dors ped__
__bilateral BP's asymmetrical_____

T = tenderness
G = guarding
R = rebound
m = mild
mod = moderate
sv = severe



ABDOMEN (GI)
__non-tender __tenderness / guarding / rebound_____
__no organomegaly __abnml bowel sounds_____
__no distention __hepatomegaly / splenomegaly / mass_____
__nml bowel sounds* __bruit / pulsatile mass_____

RECTAL
__non-tender __black / bloody / heme pos. stool_____
__heme neg stool __tenderness_____

SKIN
__color nml, no rash __cyanosis* / diaphoresis* / pallor_____
__warm, dry __skin rash zoster-like_____
__embolic lesions / signs of IVDA_____
__decubitus_____

EXTREMITIES (MS)
__non-tender / nml ROM* __pedal edema*_____
__no pedal edema __calf tenderness / Homan's sign_____

P Q R I **NEURO / PSYCH**
__oriented x3 __disoriented to person / place / time_____
__mood / affect nml __depressed mood / affect_____

__CN's nml as tested __facial droop_____
__motor nml
__sensation nml

Underline indicates organ system
* equivalent or minimum required for organ system exam

Chest Pain – 33

LABS, EKG & X-RAYS

CBC	Chemistries	1st Set	PT/PTT
normal except	normal except	CK	INR
WBC	Gluc	CKMB	D-Dimer
Hgb	BUN	Troponin	BNP
Hct	Creat	2nd Set	Cultures sent
Platelets	Na	CK	blood x
segs	K	CKMB	sputum
bands	CO2	Troponin	

RHYTHM STRIP __NSR __Rate_____

P Q R I **EKG** __NML ☑ Interp. by me ☐ Reviewed by me Rate_____
__NSR __nml intervals __nml axis __nml QRS __nml ST/T
not / changed from:_____
Repeat EKG - pending / __unchanged / _____

CXR ☑ Interp. by me ☐ Reviewed by me ☐ Discsd w/ radiologist
__nml / NAD __no infiltrates __nml heart size __nml mediastinum

CT Scan chest / abdomen V/Q Scan ☐ Discsd w/ radiologist
__nml / NAD

P Q R I **Pulse Ox** ____% on RA / ____L O_2 Interp: nml / hypoxic Time:_____

PROGRESS

Time_____ unchanged improved re-examined
pain not gone completely_____

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/30/11 RM/BED: /
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ATT: ILIA HANNA #: 4950
MR #: 000028132 PAT #: 1032224

Rx given_____

__antibiotics given_____

♦ CP/AMI - EKG / ASA / B-Blocker / Thrombolytics / PCI / transfer_____
♦ CAP - SaO_2 / VS / MSE / antibiotic(s) / pathogen / BC / CXR or CT / transfer_____

Clinical Tool Box
__TIMI ACS risk
__PERC / Well's PE
__CURB-65 / PORT

Discussed with Dr._____ Additional history from:
or Cardiologist at _____ AM / PM family caretaker paramedics
will see patient in: ED / hospital / office

Counseled patient / family regarding: lab / rad results diagnosis need for follow-up
__Smoking cessation: discussed: plan / triggers / challenges / gave Rx time:____min
CRIT CARE TIME (excluding separately billable procedures)
30-74 min 75-104 min ____ min

CLINICAL IMPRESSION

♦ Chest Pain - acute
precordial / tightness / pressure
chest wall / discomfort / angina
Dyspnea - acute
♦ Myocardial Infarction - acute
♦ Pneumonia
Pleurisy / Pleuritis
Aortic Dissection
Pericarditis
Pneumomediastinum
Pneumothorax
Pulmonary Edema / CHF
Pulmonary Embolism

DISPOSITION- ☐ transferred ☑ home ☐ expired ☐ AMA_____
Time_____ ☐ admitted OBS __POA decubitus / UTI (foley) _____
Follow Up- ☐ arranged less than 24 hours _____
CONDITION- ☐ critical ☐ improved ☐ stable ☐ unchanged
Care transferred to Dr._____ Time:_____

PHYSICIAN SIGNATURE- _____ RTI # 96 J
☑ Template Complete ☐ See Addendum (Dictated / Template #_____)

6-14-52

25 Mark (✓) or circle appropriate response.

MACON COUNTY GENERAL HOSPITAL
Triage/Nurses Notes
GENERAL ADULT

ER Record #: 134017 Age: 58 M/F
Name: Cherry, Pamela J.
PCP: Maxwell

HPI: Pain from neck & jaws down to mid chest onset 2-3 hrs ago while sitting on table & wing – been "hurting" all day

Assoc. symptoms: Burns like pain no V X nausea

Treatment PTA:

Pain level: (0-10) 10 other:
comments:
B/P 157 P 94 R 24 T 97 Ht Wt 122 kg/lb
LMP: O2 Sat 99 O2 24/M
Triage Nurse: waiting room: LWBS ☐
Exam Room # Time: 1920 Safety measures implemented ☐

ALLERGIES: Latex: Y/N NKA

MEDS: Simvastatin, Zoloft, Levothyroxine see list ☐

PMH/PSH: Chronic, Cholecystectomy, Hypothyroidism, Anxiety – smokes 1 ppd

Airway/Breathing: WNL ☑ other:
Circulation: WNL ☑ other:
Skin color/temp/turgor: WNL ☑ other:
AAO x 3 ☑ other:
MAE: Y/N equal hand grasps: Y/N equal leg strength: Y/N
Monitor: Y/N initial rhythm: pharmacist ☐
Head/Face: WNL ☑ other:

Neck: WNL ☑ other:
Chest/heart tones: WNL ☑ other:
Abdomen/Flanks: WNL ☑ other:
GU/GYN: WNL ☑ other:
Pelvis/Perineum: WNL ☑ other:
Upper Extremities: WNL ☑ other:
Lower Extremities: WNL ☑ other:
Posterior Surface: WNL ☐ other: Sun burn on upper back

Lab: Y/N drawn: by: NURSE lab staff complete: 2013 CBC: Y/N
ABG: Y/N drawn: complete:
Xray: Y/N in progress: complete:
Urine: Y/N CMS · CATH collected: to lab: complete: C&S: Y/N
CT: Y/N in progress: complete: Nurse w/pt to CT ☐
EKG: Y/N requested: 1920 completed: 1920 reviewed by:
Primary Nurse/Assessment Time: RN 1916

MODE OF ARRIVAL Date: 5-29-11 Time: 1915
w/c ☐ ambulatory ☑ carried ☐ stretcher ☐
EMS other:
immobilized ☐ O2 ☐ meds(see narrative) ☐ other:
IV ☐ site/size/fluid/rate/TBA
Acuity: 1 Critical 2 Emergent (3 Urgent) 4 Nonurgent 5 Minor
Communication barrier: Y/N Interpreter:
Do you or have you/your immediately family have/had TB? Y/N
Do you have any of the following: cough > 2wks: Y/N bloody sputum: Y/N night sweats: Y/N weight loss: Y/N loss of appetite: Y/N fever: Y/N
Mobility Problems: Y/N
Indications of Abuse/Neglect: Y/N see narrative ☐

IMMUNIZATIONS: UTD ☐ Unknown ☐ > 5yrs ☐
Td / TT 0.5ml IM time: site: by
Manuf. Lot # Exp. date.

TIME	PROCEDURE	Comments	INI

TIME	BP	P/rhythm	R	T	O2 sat	PL

TIME	NARRATIVE (cont.)	INI
2000	Resting in bed c Visitor @ side Breathing easy	
2025	NS Bolus Complete	
2100	EDP @ bedside discussing plan of care	

see continuation sheet ☐

Discharged ☒ Admit ☐ to home @ 2150
other:
Via: w/c ☐ stretcher ☐ arms ☐ ambulatory ☒
Condition: improved ☐ stable ☒ unstable ☐ critical ☐
VS: B/P 110/75 P 84 R 20 T 97.1 PL 9/10
Written/verbal inst. given to: patient ☒ caregiver ☐ verb understanding ☒
sedation warnings given ☐ driver here for pt ☐
valuables sent w/pt: Y/N Discharged by

SIGNATURE	INI	SIGNATURE	INI
RN		RN	

CHRONOLOGY	Paged	Notified/Comments	Exam Time
EDP:			1923
PCP:			
Consult:			
Consult:			

Preferred method of learning:
Verbal Written (Combination)
Initials:

TIME	NARRATIVE	INIT.

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/30/11 RM/BED: /
ATT: ILIA HANNA
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032224

Form #25 © ENDS 4/2000, Rev. 12/29/01

Macon County General Hospital

Date:

Emergency Room Medication Administration Record

Time	Medication / IV Fluid	Amount	Route	Site	Nurse	Response	*Time Complete (See legend)	Comments
2005	Nitroglycerin	0.4mg	SL			No Reaction / Improved ___/10 / Other	I A I T	NO A
2009	IV	500cc	Bolus			No Reaction / Improved ___/10 / Other	I A I T	BP 134/87
2120	Toradol	30mg	IM			X No Reaction / Improved 8/10 / Other	I A I T	States pain 2/10 after tx
						No Reaction / Improved ___/10 / Other	I A I T	
						No Reaction / Improved ___/10 / Other	I A I T	
						No Reaction / Improved ___/10 / Other	I A I T	
						No Reaction / Improved ___/10 / Other	I A I T	
						No Reaction / Improved ___/10 / Other	I A I T	

*Time Complete Legend: A-Continued at admission T-Continued at Transfer

Time	Site	Catheter Size	Attempts	Solution	Rate	By	Comments
#1 1942	DAC	24 gauge 18 gauge / 22 gauge 16 gauge / X20 gauge / IO needle___		X Saline Lock	@___ mL/hr / X Saline Flush		IV Fluids DC'd Time:___ Init.___ / X IV DC'd Time: 2142 Init. / X Site Clear/Cath Intact / Continued at Admission / Continued at Transfer
#2		24 gauge 18 gauge / 22 gauge 16 gauge / 20 gauge / IO needle___		Saline Lock	@___ mL/hr / Saline Flush		IV Fluids DC'd Time:___ Init.___ / IV DC'd Time:___ Init.___ / Site Clear/Cath Intact / Continued at Admission / Continued at Transfer

Time In-house O2 started	Oxygen	Route	Nurse	Time Stopped	Comments
___	O2 @ ___ L/min	Nasal Cannula / Simple Mask / Venti-mask / Non-Rebreather / Transport Ventilator		Continued at Admission / Continued at Transfer / Time:___	

Nurse Signature	Init.	Nurse Signature	Init.

Physician Signature

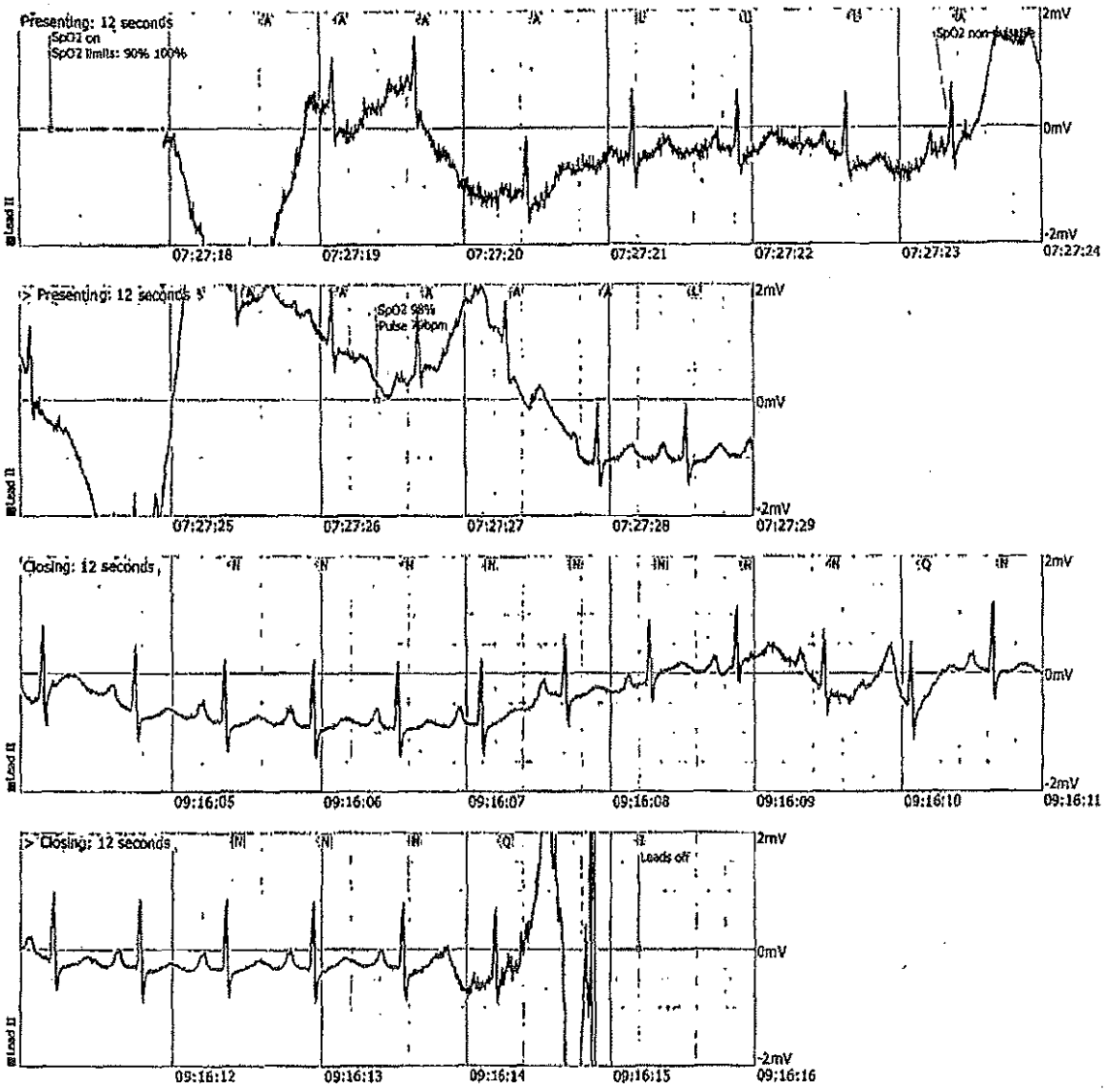
CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/30/11 RM/BED: /
PCP: MARGARET MAXWEL #: 0
ATT: ILIA HANNA #: 4950
MR #: 000028132 PAT #: 1032224

SKH 134017

ECG Pre- and Post-shock

HEARTSTART
Event Review Pro / Hospital 4.1

Case ID:	1105301927155216	**Patient ID:**	[redacted]
Case date:	5/30/2011	**First name:**	PAMELA
Device:	HeartStart MRx: US00540164	**Last name:**	CHERRY



Vital Trends

HEARTSTART
Event Review Pro / Hospital 4.1

Case ID:	1105301927155 2f6	**Patient ID:**	[redacted]
Case date:	5/30/2011	**First name:**	PAMELA
Device:	HeartStart MRx: US00540164	**Last name:**	CHERRY

Vital Trend	19:27:00	19:32:00	19:37:00	19:42:00	19:47:00	19:52:00	19:57:00	20:02:00
HR (bpm)	86^	94^	95^	100^	98^	97^	101^	90^
SpO2 (%)	99^	98^	100^	99	99^	97^	97^	97^
Pulse (bpm)	83^	94^	100^	99	95^	95^	101^	91^
NBP systolic (mmHg)	--	--	--	--	124	--	--	127
NBP diastolic (mmHg)	--	--	--	--	84	--	--	88
NBP mean (mmHg)	--	--	--	--	97	--	--	101

Vital Trend	20:07:00	20:12:00	20:17:00	20:22:00	20:27:00	20:32:00	20:37:00	20:42:00
HR (bpm)	93^	95^	--	91	95^	95^	94^	89^
SpO2 (%)	96^	94^	95^	97^	--	--	--	--
Pulse (bpm)	93^	94^	90^	94^	--	--	--	--
NBP systolic (mmHg)	--	--	124	--	--	124	--	--
NBP diastolic (mmHg)	--	--	87	--	--	87	--	--
NBP mean (mmHg)	--	--	99	--	--	99	--	--

Vital Trend	20:47:00	20:52:00	20:57:00	21:02:00	21:07:00	21:12:00	21:17:00	21:22:00
HR (bpm)	94^	91^	97^	92^	93^	83	--	--
SpO2 (%)	--	--	--	--	--	--	--	--
Pulse (bpm)	--	--	--	--	--	--	--	--
NBP systolic (mmHg)	131	--	--	127	--	--	--	--
NBP diastolic (mmHg)	95	--	--	88	--	--	--	--
NBP mean (mmHg)	107	--	--	101	--	--	--	--

MACON COUNTY GENERAL HOSPITAL
CHERRY, PARLEY J
58 Years F 06/24/1952 Caucasian
Measurements
Rate 92 bpm
Interpretation
12S - Interpretation
Sinus rhythm with sinus arrhythmia
Right atrial enlargement
Rightward axis
Possible Anterior infarct , age undetermined
Abnormal ECG
Unconfirmed report
Order Physician ILIA, HANNA
Technician JS
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
12-Lead
PRINTED IN U.S.A.

Print date: 6/14/12 16:37 **PATIENT REPORT** Page 1
Printed by: CCARTER **** FINAL ****

MACON COUNTY GENERAL HOSPITAL
P.O. BOX 378
LAFAYETTE TN 37083

LABORATORY CLIA#44D0307212
JULIE LEMMON, M.D.

Name: **CHERRY PAMELA J** Status: O/P / EMR Adm Date: **5/30/11**
Pat#: 1032224 [redacted] Adm Phys: ILIA HANNA
Strt: 5/30/11 19:38 Age/Sex: 58 / F Ord Phys: ILIA HANNA
Ord#: R 100 200 300 400 MR#: 000028132 Fam Phys: MARGARET MAXWEL
500

Special Instructions:
Reported: 5/30/11 20:08

Test Name	Result	Flag	Reference Range	Units
Collected: 5/30/11 19:44 ER Received: 5/30/11 19:44 CS Verified: 5/30/11 19:45 CS				
CBC WITH AUTO DIFF				
WBC COUNT AUTO	14.4	H	4.8 - 10.8	10^3/mcL
RED BLOOD CELL	3.99	L	4.20 - 5.40	10^6/mcL
HEMOGLOBIN	13.2		12.0 - 16.0	G/dL
HEMATOCRIT	39.5		37.0 - 47.0	%
MCV	98.9		81.0 - 99.0	FL
MCH	33.0	H	27.0 - 31.0	pg
MCHC	33.4		32.0 - 36.0	g/dL
RDW	11.4		11.5 - 15.5	%
PLATELET COUNT AUTO	291		130 - 400	10^3/mcL
MEAN PLATELET VOLUME	7.3	L	7.4 - 10.4	FL
NEUTROPHIL %	84.8	H	50.0 - 75.0	%
LYMPHOCYTE %	10.1	L	20.5 - 45.5	%
MONOCYTE %	4.0	L	5.5 - 11.7	%
EOSINOPHIL %	0.9		0.9 - 2.9	%
BASOPHIL %	0.2		0.2 - 1.0	%
NEUTROPHIL ABSOLUTE #	12.2	H	2.2 - 4.8	10^3/mcL
LYMPHOCYTE ABSOLUTE #	1.5		1.3 - 2.9	10^3/mcL
MONOCYTE ABSOLUTE #	0.6		0.3 - 0.8	10^3/mcL
EOSINOPHIL ABSOLUTE #	0.1		0.0 - 0.2	10^3/mcL
BASOPHIL ABSOLUTE #	0.0		0.0 - 0.1	10^3/mcL
MANUAL DIFFERENTIAL			-------	-------
Collected: 5/30/11 19:43 ER Received: 5/30/11 19:43 CS Verified: 5/30/11 20:08 CS				
COMPREHENSIVE METABOLIC PANEL				
GLUCOSE	118	H	70 - 110	mg/dL
BLOOD UREA NITROGEN	16		7 - 18	mg/dL
CREATININE	0.9		0.6 - 1.3	mg/dL
BUN/CREATININE RATIO	17.8		6.0 - 20.0	
GFR	64		60	ml/min/1.73m2
SODIUM	139		136 - 145	mmol/L
POTASSIUM	3.3	L	3.5 - 5.1	mmol/L
CHLORIDE	102		98 - 107	mmol/L
CARBON DIOXIDE	30.1		21.0 - 32.0	mmol/L

Continue ...

MACON COUNTY GENERAL HOSPITAL
P.O. BOX 378
LAFAYETTE TN 37083

LABORATORY CLIA#44D0307212
JULIE LEMMON, M.D.

Name: **CHERRY PAMELA J** Status: O/P / EMR Adm Date: **5/30/11**
Pat#: 1032224 Adm Phys: ILIA HANNA
Strt: 5/30/11 19:38 Age/Sex: 58 / F Ord Phys: ILIA HANNA
Ord#: R 100 200 300 400 MR#: 000028132 Fam Phys: MARGARET MAXWEL
500

Special Instructions:
Reported: 5/30/11 20:08

Test Name	Result	Flag	Reference Range	Units
ANION GAP	10.2		10.0 - 18.0	mmol/L
TOTAL PROTEIN	6.8		6.4 - 8.2	g/dL
ALBUMIN SERUM	3.3	L	3.4 - 5.0	g/dL
GLOBULIN	3.5		2.0 - 3.9	g/dL
ALBUMIN/GLOBULIN RATIO	0.9	L	1.0 - 2.4	
CALCIUM	8.7		8.5 - 10.1	mg/dL
OSMOLALITY CALCULATED	280		275 - 295	mOsm/L
BILIRUBIN TOTAL	0.20		0.00 - 1.00	mg/dL
ALKALINE PHOSPHATASE	103		50 - 136	U/L
AST/SGOT	18		15 - 37	U/L
ALT/SGPT	21	L	30 - 65	U/L

Collected: 5/30/11 19:43 ER Received: 5/30/11 19:43 CS Verified: 5/30/11 20:08 CS
CK MB

CK MB	1.9		0.0 - 3.6	ng/mL

Collected: 5/30/11 19:43 ER Received: 5/30/11 19:43 CS Verified: 5/30/11 20:08 CS
MAGNESIUM

	1.8		1.8 - 2.4	mg/dL

Collected: 5/30/11 19:43 ER Received: 5/30/11 19:43 CS Verified: 5/30/11 20:08 CS
TROPONIN-I

	0.06		0.00 - 0.10	ng/mL

MACON COUNTY GENERAL HOSPITAL | LAFAYETTE, TN 37083 | ER / OUTPATIENT TREATMENT

AFTERCARE INSTRUCTIONS TO PATIENTS

The examination and treatment you have received in the Emergency Department has been rendered on an EMERGENCY basis ONLY and is not intended to be as substitute for an effort to provide COMPLETE medical care. Your listed family physician will be provided with a copy of this visit for continuity of your care. It is important that you let him check you again and that you report to him any new or remaining problems at that time. This is necessary because it is IMPOSSIBLE to recognize and treat ALL elements of illness or injury in a single Emergency Department visit. Meanwhile FOLLOW THE INSTRUCTIONS INDICATED FOR YOU BELOW.

SPRAIN, FRACTURE AND SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours. Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times. Wait 24 hours for the cast to become strong before you allow pressure or weight on any part of the cast.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast- this should be done often if it does not cause pain.
- ☐ If the part swells anyway, or gets cold, blue or numb, or pain increases markedly, have it checked promptly.

BACK OR NECK INJURY INSTRUCTIONS

- ☐ Use heat or cold on the injured area - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movements that make pain worse.
- ☐ Relax emotionally - If you are tense, the problem will only be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps clear soreness.

WOUND CARE (CUTS, ABRASIONS, BURNS, ETC.)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus, or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Clean stitches with Peroxide or Betadine Solution, then apply Neosporin Ointment and bandage.
- ☐ Dressings should be changed in _____ days.
  - ☐ Change them.
  - ☐ Call and see your doctor.
- ☐ Tetanus Toxoid given. _____

FOLLOW - UP INSTRUCTIONS

- ☒ Call to arrange an appointment at his office to see Dr. Margaret Maxwell in ___ days for follow-up care. **Call sooner if you think necessary.** His phone. _____.

HEAD INJURY INSTRUCTIONS

Report to your doctor immediately if anything listed occurs (even within several months.)

- ☐ Persistent vomiting, stiff neck, fever.
- ☐ Unequal pupils (one pupil large, one small).
- ☐ Confusion or unusual drowsiness.
- ☐ Convulsions or unconsciousness.
- ☐ Stumbling or other problems with normal use of arms or legs, or areas of skin numbness.

NOTE: Wake patient hourly the first night to check for these signs.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by the Radiology Dept. If any abnormalities are found that have not been called to your attention, your doctor will be notified. (Please be certain that the Emergency Dept. has the name of your family doctor.)

Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken.

GENERAL INSTRUCTIONS

- ☐ Stay in bed / may go to the bathroom.
- ☐ Use vaporizer.
- ☐ Take clear liquids by mouth until nausea, vomiting, diarrhea and abdominal cramps subside, then gradually return to normal diet.
- ☐ Drink large amounts of liquid.
- ☐ Take _____ Tylenol every 4 hours. Stop after 48 hours.
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ No weight bearing, use crutches.
- ☒ Fill prescriptions given to you from Emergency Dept. and take as directed.
- ☐ Warm soaks to area 4 times daily, 20 to 40 minutes each time.
- ☐ Stop smoking
- ☐ Fever control instructions given.
- ☐ Do not drive or operate machinery while taking medication, _____
- ☐ Apply ice packs to area.
- ☐ Wear eye patch for _____ hours.
- ☐ See patient home medication list.
- ☐ Post sedation / pain mediation instructions.

ADDITIONAL INSTRUCTIONS / EDUCATIONAL HANDOUTS: _____

Return to ER as needed

I hereby acknowledge receipt of all the instructions as indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my condition worsens or if new symptoms appear, I should contact my Doctor immediately, or if unable to reach my doctor, return to the Emergency Room. I understand that if I receive a medication to take home with me, it may not be in a childproof container and I am assuming responsibility for safe storage.

PATIENT OR GUARDIAN SIGNATURE	DATE	WITNESS SIGNATURE
X [redacted]	5/30/11	[redacted]

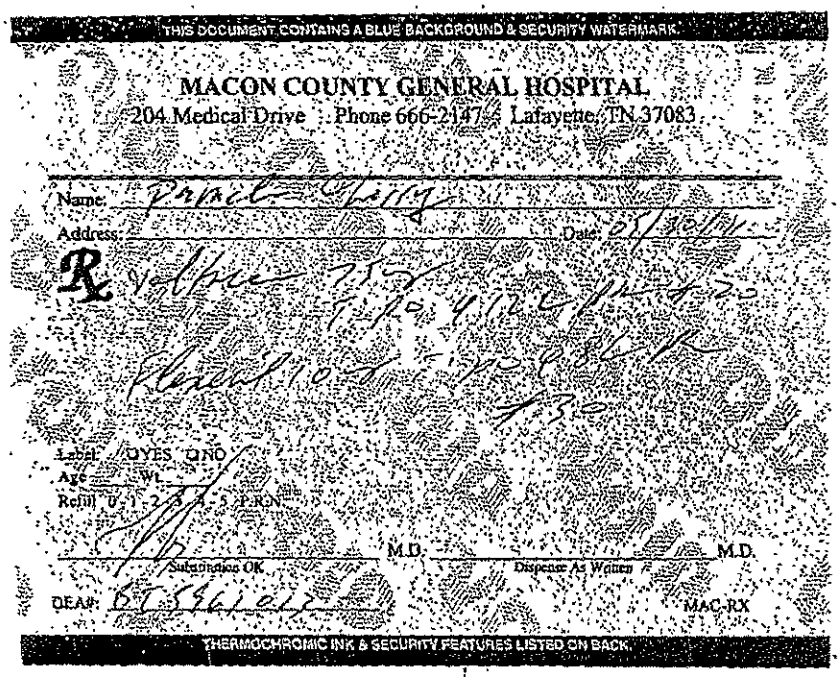
CHERRY PAMELA J [redacted] AGE: 58 SEX: F NSV: EMR
ADMIT: 05/30/11 RM/BED: /
ATT: ILIA HANNA
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032224

MCGH Phone: 666-2147

134017

MEDICAL RECORDS

MCGH0013



THIS DOCUMENT CONTAINS A BLUE BACKGROUND & SECURITY WATERMARK

MACON COUNTY GENERAL HOSPITAL
204 Medical Drive ; Phone 666-2147 ; Lafayette, TN 37083

Name:

Address: Date:

℞

Label: ☐YES ☐NO
Age: Wt.:
Refill: 0 - 1 - 2 - 3 - 4 - 5 P.R.N.

Substitution OK M.D. Dispense As Written M.D.

DEA#: MAC-RX

THERMOCHROMIC INK & SECURITY FEATURES LISTED ON BACK.

CHERRY PAMELA J [redacted] HSV: EMR
AGE: 58 SEX: F
ADMIT: 05/30/11 RM/BED:
ATT: ILIA HANNA
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032224

MACON COUNTY GENERAL HOSPITAL
P O BOX 378
LAFAYETTE, TN 3708:
615-666-2147

CHERRY PAMELA J [redacted] HSV: EMR
ADMIT: 05/30/11 AGE: 58 SEX: F
ATT: ILIA HANNA RM/BED:
MR #: 000028132 PAT #: 1032224

NOTICE TO OUR PATIENTS AND/OR THEIR REPRESENTATIVE

In order to be able to offer the healthcare services needed by our community, Macon County General Hospital has contracted with independent contractors who have been granted the privilege of using the facilities at Macon County General hospital for the care and treatment of their patients. However, they are ***NOT*** employed by the hospital. Organizations and/or individuals that will provide services and/or patient care in Macon County General Hospital facilities and will generate a separate bill include but are not limited to:

PICC Line Insertion	Podiatrist
Anesthesia	Cardiologist
Surgeons	Gastroenterologist
ER Physicians	Ophthalmologist
Radiologist	Dentist
Pathologist	Orthopedics
Physicians seeing patients in Specialty Clinic	Ambulance/Helicopter Services

If you have any questions about these arrangements, please ask a registration specialist for assistance.

If you have any questions about these separate bills, please call the number on the bill.

The above information has been explained to me and I understand that the above organization/individuals are not employees of Macon County General Hospital and that I will be billed separately for the services of any of the above groups.

Patient's Signature _____ Date _____

Representative's Signature [signature] Date 5-30-11

MAC-365 Rev. 12-09 Reorder from Two Pelni Inc. 1-800-500-5876

MACON COUNTY GENERAL HOSPITAL
Lafayette, Tennessee 37083

CHERRY PAMELA J
ADMIT: 05/30/11 AGE: 58 HSV: EMR
ATT: ILIA HANNA RM/BED: SEX: F
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032224

Patient Name

1. **Authorization for Treatment:** This is to certify that I (we) the undersigned request treatm[illegible] l treatments considered necessary for the patient whose name appears below. I voluntarily consent to the rendering of [illegible] ployees and authorized agents of MCGH as deemed necessary or beneficial in their professional judgment. I acknowledge that no guarantees have been made [illegible] fect of such examination or treatment of my condition. I understand that as part of my healthcare, MCGH originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment and any plans for further care or treatment. I understand that this information will be used by hospital employees as a basis for planning my care and treatment, and as a means of communication among the healthcare professionals who contribute to my care. I realize that copies of this visit may be forwarded to my listed attending physician for continuity of care; and I understand that it may be necessary for MCGH or my attending physician to make available to other healthcare providers, copies of my medical records for information relating to my care for follow-up or continued care. I understand that I must instruct MCGH otherwise if I wish copies of this visit NOT to be forwarded to my attending physician or other healthcare providers. Authorization is hereby granted for such treatment and procedures.
- For ER Patients Only: I(we) understand that a personal physician is to be selected by or on behalf of the patient within 24 hours of hospitalization if further treatment is required or immediately if complications arise.

2. **Assignment of Insurance Benefits and Release of Information:** I hereby authorize payment directly to MCGH for entitled benefits arising out of any policy of insurance insuring patient or any other party liable to patient and hereby assign any group, individual, Medicare and/or Medicaid payment due me to Macon County General Hospital benefit for application on patient's bill. I also authorize the Hospital to transfer any overpayment to other accounts for which I am responsible. Furthermore, I agree that if my care is handled under the Workers Compensation Act the agent is hereby authorized to have access to, or request copies of my hospital record. I also authorize payment directly to all Physicians, Radiologist, Pathologist, and Anesthesiologist performing services to me or for me through MCGH of all benefits which may be due and payable under insurance coverage that I may have. I hereby authorize MCGH and physicians to furnish any medical information and/or copies of my hospital record as requested by insurance companies with whom I have coverage. A carbon or photostatic copy of this signature shall be considered as valid as the original. Medicare-Medicaid Patient's Certification: I certify that the information given by me in applying for payment under Titles XVIII and/or XIX of the Social Security Act is correct. I authorize release of all records required to action this request. I request that payment of authorized benefits be made on my behalf.

3. **Financial Agreement and Payment Guarantee:** For and in consideration of the services rendered to the patient by MCGH, I (we) do hereby guarantee payment of all charges incurred to the account of the named patient from time of admission until discharge. I (we) the undersigned agree to pay reasonable attorney's fees and collection expenses associated with this account should it be referred to an attorney for collection.

4. **Waiver of Hospital Responsibility for Patient Valuables:** MCGH will endeavor to take all necessary precautions to safeguard personal articles and valuables of patients being treated at the hospital; however MCGH shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, coats or other articles brought to the hospital. I understand all personal property must be collected at the time of discharge from the hospital.

5. **Infection Control Consent:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient at MCGH. If, for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. These results will be kept confidential as provided by Tennessee State Law.

6. **Patient Rights and Responsibilities:**
Do you currently have Hospice? No ✓ Yes _____ (agency) _____
Do you currently have Home Health? No ✓ Yes _____ (agency) _____
I have been offered a copy of the Patient Rights and Responsibilities. X PLC (initials)

7. **Privacy Notice Acknowledgement:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. By initialing the line below, you acknowledge your receipt of our Notice of Privacy Practices.
I have received a copy of Macon County General Hospital's Notice of Privacy Practices. X PLC (initials)

8. **Appointment Reminders and Follow-up Calls:** I give my consent for MCGH to leave a message or voice mail in reference to my hospital visit for items such as appointment reminders, insurance items, and/or test results. X _____ (initials) Phone number: _____

9. **Advance Directives:**
Do you have a Durable Power of Attorney for Healthcare? No ✓ Yes _____ (name) _____ (phone) _____
Do you have a Living Will? No ✓ Yes _____
If Yes, is a copy available? No _____ Yes _____ If copy not available, content of advanced directives includes: _____

10. **Request for Private Room:** In the event that I am admitted, I would like to request a Private Room, if available? X _____ (initials)

11. **Patient Directory:**
I hereby give permission to MCGH to include my name, location within the hospital, and general condition (good, fair, stable) to the following:

✓ Anyone who inquires
_____ **DO NOT** include in Directory

During my stay in the hospital, I hereby give permission to MCGH to share my general condition and details of my care with the following people.

Name _____ Relationship _____
Name _____ Relationship _____

X _____
Patient's Signature Date

X David Chinn Spouse
Guardian if Minor/Authorized Person Relationship

X Cheyenne Collins 5-30-11
Witness Date

TELEPHONE PERMISSION FOR TREATMENT

This patient is an unemancipated minor _____ years of age, and unable to sign for treatment. Telephone consent is given on the patient's behalf by:

Name of Representative Relationship
1st Witness of Telephone Call Date & Time
2nd Witness of Telephone Call Date & Time

REFUSAL OF TREATMENT – MEDICAL SCREENING – DISCHARGE AGAINST MEDICAL ADVICE

This is to certify that I, _____, have refused medical care and treatment and am leaving MCGH against medical advice of the attending physician and the hospital staff. I acknowledge that I have been informed of the risk(s) involved, which include: _____ and hereby release all concerned (physician, hospital, and employees) from all responsibility and any ill effects which may result from my action.

Signed _____ Witness _____ Date _____

Patient: Pamela J Cherry
First Last
DOB: [redacted]
Social Security #: [redacted]
Complaint: Jaw pain
Chest Pain
Family Physician: Margaret Maxwell
Time of Arrival: 7:15
MAC-4x3 (Rev. 07-10) Two Point Inc. 1-800-800-5876

Patient: Pamela J Cherry
First [redacted] Last
DOB: [redacted]
Social Security #: [redacted]
Complaint: Jaw pain
Chest Pain
Family Physician: Margaret Maxwell
Time of Arrival: 7:15
MAC-4x3 (Rev. 07-10) Two Point Inc. 1-800-800-5876

Anthem.

PAMELA J CHERRY
Identification Number
[redacted]

HIA PLAN

Group: [redacted]
HIA
Plan Codes:
BIN#:
PCN: [redacted]

Copayment $0

PPO ℞

Anthem.

anthem.com

Please submit claims to local Blue plan. If Medicare is primary, please file claims with Medicare. If a provider does not file claims on your behalf, please file claims to:
Anthem Blue Cross and Blue Shield
P.O. Box 37010
Louisville, KY 40233

Member Services	1-877-883-9566
24/7 NurseLine	1-888-400-8780
Pre Certification	1-888-778-4703
Pharmacy Provider Services	1-800-842-0210
Coverage While Traveling	1-800-810-2583
Provider Services	1-800-676-2583

Possession of this card does not guarantee eligibility for benefits.

Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

134032

MRSA:
VRE:

MACON COUNTY GENERAL HOSPITAL

204 Medical Drive • Lafayette, Tennessee 37083 • (615) 666-2147

Advance Directive: N

REGISTRATION ADMISSION

PATIENT ACCOUNT NO.	MEDICAL RECORD NO.
1032247	000028132

PATIENT (Name, Address, Phone)

CHERRY PAMELA J
1152 FLETCHER AVENUE

INDIANAPOLIS IN
46203
COUNTY: MARION
PHONE: (317)683-4716

BIRTH DATE	AGE	SEX	RACE	PRIM. LANGUAGE	SOCIAL SECURITY NO.
[redacted]	58	F	W		[redacted]

MAR. STATUS	REL	FC	ADMITTED BY	HIPAA NM	HIPAA RM	HIPAA REL	HIPAA COND
M	Q	B	SBR	Y	Y	Y	Y

ADMISSION DATE & TIME	DISCHARGE DATE & TIME	SERVICE	ROOM / BED NO.
05/31/11 07:18	05/31/11 08:44	EMR	/

PATIENT EMPLOYER (Name, Address, Phone, Occ)

FARM BUREAU

PHONE:
OCC:

EMERGENCY CONTACT 1 (Name, Address, Phone, Rel)

CHERRY DAVID

PHONE: (317)683-4716
REL: SPOUSE

EMERGENCY CONTACT 2 (Name, Address, Phone, Rel)

REL:

GUARANTOR (Name, Address, Phone, Rel)

CHERRY PAMELA J
1152 FLETCHER AVENUE
INDIANAPOLIS IN
46203
PHONE: (317)683-4716
SSN: [redacted]
REL: SELF

GUARANTOR EMPLOYER (Name, Address, Phone)

FARM BUREAU

PHONE:

ATTENDING PHYSICIAN (Name, Number)

CHUNN STANLEY 4900

ADMITTING PHYSICIAN (Name, Number)

CHUNN STANLEY 4900

REFERRING PHYSICIAN (Name, Number)

0

PRIMARY INSURANCE

BLUE CROSS
ONE CAMERON HILL CIRCLE
SUITE 0002
CHATTANOOGA TN
374020000

POLICY# FBJAN2471298

GROUP #: 003321926
GRP NAME: BC
AUTH#:
CHERRY PAMELA J
SEX: F RELATION: 18

SECONDARY INSURANCE

POLICY#

GROUP #:
GRP NAME:
AUTH#:

SEX: RELATION:

TERTIARY INSURANCE

POLICY#

GROUP #:
GRP NAME:
AUTH#:

SEX: RELATION:

CHIEF COMPLAINT / ADMITTING DIAGNOSIS

COMMENTS

06/01/11 08:03
Current System Date and Time

MC1000/112409

Macon County General Hospital
Lafayette, Tennessee

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: [redacted] RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247
Pa
DC
ER

EMERGENCY DEPARTMENT

ADVANCE DIRECTIVES

☐None known
☐POA for Healthcare? Name: Phone:
☐Living Will? Content if copy not available

PHYSICIAN ORDERS

Transfer to Vanderbilt
pt. is to Dr. Mathews.

Physician Signature

Return to ER within 72 hours?
☑ Yes ☐ No

Medical Record Obtained for Review?
☑ Yes ☐ No

Laboratory Orders:
☐ Amylase
☐ Blood C&S x 2
☑ BMP
☐ BNP
☑ CBC with Diff
☑ CK-MB
☐ CPK
☐ Digoxin Level
☐ Flu Screen
☐ Free T-4
☐ Lipase
☐ Magnesium
☐ Myoglobin
☐ PT
☐ PTT
☐ RSV
☐ Sputum C&S
☐ Strep Screen
☑ Troponin
☐ TSH
☐ Urinalysis
☐ Urine C&S

Radiology Orders:
☐ CXR PA & Lat
☐ CXR Portable

Other Orders:
☐ ABG
☐ Crisis Protocol
☑ EKG
☐ Jet Neb
☐ Old Chart

134032

Unacceptable Abbreviations: U; IU; QD; QOD; MS; MSO_4; $MgSO_4$; lack of leading zero; presence of trailing zero

50 Macon County General Hospital

EMERGENCY PHYSICIAN RECORD

♦ Cardiopulmonary Resuscitation ♦

PQRI – Physician Quality Reporting Initiative

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

ER#___

Name:_

DATE:_____ TIME:_____ ☐ on arrival ROOM:_____

__EMS Arrival __EMS treatments ordered_

HISTORIAN: patient spouse paramedics

__HX / __EXAM LIMITED BY:

TRANSFER FROM:_____ ☐ see transfer record

HPI

Initial complaint(s): collapsed (found unresponsive) chest pain dyspnea abdominal pain back pain

IV @ 20 g. w.

Witnessed arrest? no / yes

Bystander CPR? no / yes

Down-time before ACLS: 20 minutes unknown

Initial findings: by paramedics

mentation	respirations	pulse
unresponsive	no respirations	none
	agonal respirations	weak

rhythm
✓ asystole
✓ vent. fibrillation
✓ PEA brady / tachy

HR___ BP___

Glucose___ mg / dl
D-stick glucometer ISTAT
by paramedics /in ED

pre-hospital treatment:

oxygen
bag-valve-mask
intubated

CPR / thumper
defibrillated x___
IV access___
IV fluids___

epinephrine___mg
vasopressin___mg
atropine___mg
amiadrone___mg
sodium bicarb___amps
lidocaine / narcan___mg

ROS

CONST
recent illness
fever / chills

EYES / ENT
problems with vision
sore throat

CVS / RESP
chest pain
shortness of breath
cough
LNMP___ preg post- menop

GI / GU
abdominal pain
problems urinating

MS / SKIN / LYMPH
joint pain
rash
swollen glands

NEURO / PSYCH
dizziness
fainting
anxiety / depression
☐ all systems neg except as marked

*CVS / RESP / NEURO components also addressed in HPI

PAST HX

cardiac disease AMI CHF A-Fib
CVA / TIA deficit
__old records ordered / summary:

diabetes Type 1 Type 2
diet / oral / insulin
hypertension

Crohn's dz

Medications __none (see nurses note)
aspirin coumadin clopidogrel

Allergies __NKDA
see nurses note

SOCIAL HX smoker drugs
alcohol (recent / heavy / occasional) occupation
living situation: alone at home in nursing home

FAMILY HX __negative

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed

INITIAL PHYSICAL EXAM

See reverse for initial rhythm and interventions

GENERAL
✓ no evidence of trauma
__unresponsive

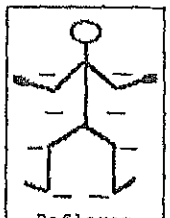
RESPIRATORY
✓ breath sounds equal bilaterally
✓ lungs clear
__no spontaneous respirations
__bag-valve-mask
__ET tube / bag-valve
__agonal respirations
__decreased air movement
__wheezes / rales / rhonchi

CVS
__spontaneous pulse present
✓ no spontaneous pulse
__chest compressions
pulse w/ CPR- none poor good
__heart sounds absent
__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__JVD present
__murmur grade___/6 sys / dias
__gallop (S3 / S4)

ABDOMEN (GI)
✓ soft, no mass
__nml bowel sounds*
__distention
__hepatomegaly / splenomegaly
__mass
__guarding

HEAD / NECK
✓ atraumatic
__pharynx clear
__head trauma
__c-spine tenderness
__tracheal deviation

NEURO
__pupils reactive
(unresponsive / agitated / confused)
__pupils fixed, dilated
__unequal pupils
size- R____mm L____mm
__no motor responses
__abnormal response to pain
withdraws flexion extension
__Babinski reflex (R / L)
__reflexes absent


Reflexes

EXTREMITIES (MS)
__no signs of trauma
__nml ROM*
__rigidity
__pedal edema (R / L)

SKIN
✓ no rash
__pallor
__cyanosis
__dependent lividity
__decubitus

Underline indicates organ system
* equivalent or minimum required for organ system exam

Pt. Name______________________ Date______________

INITIAL EKG MONITOR RHYTHM

~~asystole~~ (ventricular fibrillation) ~~narrow complex~~ ventricular tachycardia | wide complex, narrow complex, tachycardia, bradycardia, rate=_____ | sinus rhythm, atrial fibrillation, heart block 1º 2º 3º

PROCEDURES & INTERVENTIONS

☐ Time out performed

__CPR________

__intubated by: ~~ED physician~~ paramedic
with #____ET tube curved / straight blade nasal / oral
Premedication:
RSI etomidate succinylcholine vecuronium
Post- intubation- Breath sounds
equal R greater than L L greater than R
Pulse Ox: ______ End-tidal CO2 detector:______

__central line placed *sterile technique betadine prep*
right / left internal jugular subclavian femoral

__pacemaker *external / transvenous*
__defibrillated X 2
✓ foley catheter____

Electrical shock x1.
Given a Amp of epi
varying episodes of PEA c̄
sinus Rhythm.

7:55 HR - 100 BP 140/80
ABG - PO2 - 300's
PCO2 - 38
Bicarb - ~20
given Amp of Bicarb.

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

LABS, EKG & XRAYS

CBC	Chemistries		UA
normal except	*normal except*		*normal except*
WBC____	Gluc____	CK____	WBC____
Hgb____	BUN____	CKMB____	RBC____
Hct____	Creat____	Troponin____	bacteria____
Platelets____	Na____	PT/PTT____	dip:____
segs____	K____	INR____	
bands____	CO2____		

ABGs
time:____ RA /__LO2 pH____ pCO2____ pO2____ HCO3____
time:____ RA /__LO2 pH____ pCO2____ pO2____ HCO3____

RHYTHM STRIP __NSR __Rate______

EKG __NML ☐Interp. by me ☐Reviewed by me Rate____
PQRT __NSR __*nml intervals* __*nml axis* __*nml QRS* __*nml ST/T*
not / changed from:________ repeat EKG- __unchanged /____

CXR ☑Interp. by me ☐Reviewed by me ☐Discsd w/ radiologist
✓*nml / NAD __no infiltrates __nml heart size __nml mediastinum*

PROGRESS

Also see CPR Flow Sheet
*Time*________ unchanged improved re-examined

Rx given______

__CPR discontinued, patient pronounced dead at______
♦AMI - *EKG / ASA / B-Blocker / Thrombolytics / PCI / transfer*______

Discussed with Dr.______ Additional history from:
will see patient in: ED / hospital / office *family caretaker paramedics*
Counseled patient / family regarding:
lab / rad. results diagnosis need for follow-up
__Smoking Cessation: *discussed: plan / trigger / challenges / gave Rx time:___min*
CRIT CARE TIME *(excluding separately billable procedures)*
30-74 min 75-104 min _____ min

CLINICAL IMPRESSION

Cardiopulmonary Resuscitation
(successful) unsuccessful
Asystole
Cardiac Rhythm Disturbance
V. Tach. V. Fib. A. Fib. SVT
♦Myocardial Infarction - *acute*
Pulmonary Edema
Pulseless Electrical Activity
Respiratory Failure
Sudden Death

DISPOSITION- ☐ admitted __POA *decubitus / UTI (foley)*____
Time______ ☐ Medical Examiner ☐ morgue ☐ transfer____
CONDITION- ☐ unchanged ☐ improved ☐ stable____
☐ critical ☐ serious ☐ deceased____

Care transferred to Dr.________ Time:________

PHYSICIAN SIGNATURE- [signature] *RTI #*______
☑ Template Complete ☐See Addendum (Dictated / Template #____)

♦ Quality Measure Initiative

Cardiopulmonary Resuscitation-50

6.4.52

25 Mark (☑) or circle appropriate response.

MACON COUNTY GENERAL HOSPITAL
Triage/Nurses Notes
GENERAL ADULT

ER Record #: 134032 Age: 58 M/F

Name: Cherry Panta Tampa

PCP: Margaret Maxwell - FN

MODE OF ARRIVAL Date: 5-31-11 Time: 0716
w/c ☐ ambulatory ☐ carried ☐ stretcher ☐
EMS other:
immobilized ☐ O2 ☐ meds(see narrative) ☐ other:
IV ☐ site/size/fluid/rate/TBA
Acuity: 1 Critical 2 Emergent 3 Urgent 4 Nonurgent 5 Minor

HPI: presents in V-FIB CPR in progress shocked @ 150 biphasic ⊝ pulses ET checked for placement on arrival

Assoc. symptoms: collapsed in kitchen this AM witnessed per family
Treatment PTA: ✓ + CPR @ home
Pain level: (0-10) ∅ other: UTA
comments:
B/P ∅ P ∅ R ∅ T 96.8 O/A/T/R Ht ___ Wt 127 kg/lb
LMP: ___ n/a ☑ O2 Sat 94 r/a ☐ O2 ☑ 8.71 Bagging
Triage Nurse: [illegible] 0716 To waiting room: ___ LWBS ☑
Exam Room # ___ Time: 0716 Safety measures implemented ☑
ALLERGIES: Latex: Y/N NKA ☑ NKFA

Communication barrier: Y/N Interpreter:
Do you or Have you/your immediately family have/had TB? Y/N
Do you have any of the following: cough (>2wks): Y/N bloody sputum: Y/N night sweats: Y/N weight loss: Y/N (loss of appetite): Y/N fever: Y/N
Mobility Problems: Y/N
Indications of Abuse/Neglect: Y/N see narrative ☐

MEDS: Levothyroxine, Simvastatin see list ☐

IMMUNIZATIONS: UTD ☐ Unknown ☐ > 5yrs ☐
Td / TT 0.5ml IM time: ___ site: UTA by ___
Manuf. ___ Lot # ___ Exp. date: ___

PMH/PSH: COPD, HTN, Pulmonary HTN, (L) Shoulder
Smoker (ppd)

Airway/Breathing: WNL ☐ other: ETT 7.0 PTA @ 22 @ teeth
Circulation: WNL ☐ other: pale
Skin color/temp/turgor: WNL ☐ other:
AAO x 3 ☐ other: Pupils 1mm B/L unreactive
MAE: Y/N equal hand grasps: Y/N equal leg strength: Y/N
Monitor: Y/N initial rhythm: VF N.N alarms on ☑
Head/Face: WNL ☐ other: Pupils 1mm B/L ∅ reaction
Neck: WNL ☐ other: ashen lips
Chest/heart tones: WNL ☐ other: (—)
Abdomen/Flanks: WNL ☑ other:
GU/GYN: WNL ☐ other:
Pelvis/Perineum: WNL ☑ other:
Upper Extremities: WNL ☐ other: ⊝ pulses
Lower Extremities: WNL ☐ other: cool extremities
Posterior Surface: WNL ☐ other: ODR
Lab: Y/N drawn: 0728 by NURSE/lab staff complete: 0802 CBG: Y/N
ABG: Y/N drawn: complete:
Xray: Y/N in progress: 0727 complete: portable
Urine: Y/N CCMS CATH collected: ___ to lab: ___ complete: ___ C&S: Y/N
CT: Y/N in progress: ___ complete: ___ Nurse w/pt to CT ☐
EKG: Y/N requested: 0724 complete: 0724 reviewed by: [illegible]
Primary Nurse / Assessment Time: Nicole Cowell, RN

TIME	PROCEDURE	Comments	INI

TIME	BP	P/rhythm	R	T	O2 sat	PL

TIME	NARRATIVE	INIT.
0718	chest compressions immediately ō shock for 2 minutes. Rhythm check	NS
0720	⊕ pulses. chest compressions stopped	
0725	epi 1mg IV ō pulses lost chest compressions resumed ⊕ pulse ō compressions	nc
0727	⊕ pulses centrally chest compressions stopped	nc

TIME	NARRATIVE (cont.)	INI
0708	Unit 08 ō 65 y/o female CPR in progress. Tx given 4 Epi - 2 Atropine shocked 3-4 x's - was in PEA - 2 more shock again ETA 3-4 mins	
0728	ABG femoral stick FSBS 422	
0734	Breathing - chest compressions briefly - then return of pulses.	

see continuation sheet

Discharged ☐ Admit ☐ to ___
other: Transfer / Time 0844
Via: w/c ☐ stretcher ☑ arms ☐ ambulatory ☐
Condition: improved ☐ stable ☐ unstable ☑ critical ☑
VS: B/P 77/55 P 93 BBM T 96.9 PL ∅ ROX
Written/verbal inst. given to: patient ☐ caregiver ☐ verb understanding ☐
sedation warnings given ☐ driver here for pt ☐ Life Flight
valuables sent w/pt: Y/N Discharged by: [illegible]

SIGNATURE	INI	SIGNATURE	INI
[illegible]		[illegible]	WS
Nicole Cowell, RN	nc		

CHRONOLOGY	Paged	Notified/Comments	Exam Time
EDP: Chun			0716
PCP:			
Consult:			
Consult:			

Preferred method of learning:
Verbal Written Combination
Initials: ___

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MCGH0023

Macon County General Hospital Date:_____	Emergency Room Medication Administration Record

Time	Medication / IV Fluid	Amount	Route	Site	Nurse	Response	*Time Complete (See legend)	Comments
						No Reaction Improved ____/10 Other_____	A T	
						No Reaction Improved ____/10 Other_____	A T	
						No Reaction Improved ____/10 Other_____	A T	
						No Reaction Improved ____/10 Other_____	A T	
						No Reaction Improved ____/10 Other_____	A T	
						No Reaction Improved ____/10 Other_____	A T	
						No Reaction Improved ____/10 Other_____	A T	
						No Reaction Improved ____/10 Other_____	A T	

*Time Complete Legend: A-Continued at admission T-Continued at Transfer

Time	Site	Catheter Size	Attempts	Solution	Rate	By	Comments
#1		24 gauge 18 gauge 22 gauge 16 gauge 20 gauge IO needle_____		Saline Lock	@_____ mL/hr Saline Flush		IV Fluids DC'd Time:_____ Init._____ IV DC'd Time:_____ Init._____ Site Clear/Cath Intact Continued at Admission Continued at Transfer
#2		24 gauge 18 gauge 22 gauge 16 gauge 20 gauge IO needle_____		Saline Lock	@_____ mL/hr Saline Flush		IV Fluids DC'd Time:_____ Init._____ IV DC'd Time:_____Init._____ Site Clear/Cath Intact Continued at Admission Continued at Transfer

Time In-house O2 started	Oxygen	Route	Nurse	Time Stopped	Comments
_____	O2 @ _____ L/min	Nasal Cannula Simple Mask Venti-mask Non-Rebreather Transport Ventilator		Continued at Admission Continued at Transfer Time:_____	

Nurse Signature	Init.	Nurse Signature	Init.

Physician Signature

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

MCGH0024

10A

Page of

MACON COUNTY GENERAL HOSPITAL — **STANDARD Continuation Sheet**

Time	BP/ cap.refill	P	R	T	O2 Sat	IN/ site	OUT/ site	Meds/Titrated Infusions/Procedures	NARRATIVE	PL	INI
0735		78							RAC 20g X ? NS IVF		
									bolus started for ↓ B/P		
									Dopamine IVPB @ 10 mcg/kg/min		
0738									½ amp Bicarb 8.4% IV		
									site #2 (L) hand IV site		
									discontinued due to infiltration		
0739	89/56	90							foley cath 16F 10ml bulb		
									sterile technique Ø urine		
									out ———		WS
0740	epi	1mg	IVP						Dr. Chunn speaks c̄ husband		
									pulses ⊝ again chest		
									compressions started ———		WS
0740	72/50								⊕ pulses c/c stopped		
									2nd NS bolus started		
									18g ? stick LAC ———		WS
0749									SpO2 100% 142/82 96		
									pulse. Hendersonville Cardiologist/		
									hospital contacted for		
									possible transfer ———		WS
0754									B/P 64/45 Dopamine gtt		
									↑ 15 mcg/kg/min ———		WS
0755			SR c̄	1° AVB					⊕ pulses centrally but		
									weak. EDP remains @ bedside		
									he orders ½ amp epi		
									IV 1:10,000. ———		WS
									Rhythm changes frequently		WS
0800	159/93	133			100%				Dr. Chunn speaking c̄ Vume		
									transfer Ctr. ———		ne
0802									14 fr. NG. tube placed per		
									Wendy Stewart RT, 2nd IV		
									NS ↓ to K.V.O. ———		ne
0805									Pulses ⊕ NSR c̄ 1st° AV Block ———		ne
									small runs Vtach present. ———		ne
0807	81/58								Ice packs placed to neck		
									(B) axillary areas & (B) groins		
								:TOTALS	per Vume request. ———		ne

see continuation sheet ☐

ALLERGIES:

I & O Legend: Chest tube #1 = CT1, Chest tube #2 = CT2, Foley = F, Void = V, Emesis = E, NasoGastric tube = NG, Oral gastric tube = OG, Oral = O

other:

Physician Signature:

SIGNATURE	INI
Nicole Turner, RN	ne
W Stockard	WS

N
E
E

CHERRY PAMELA J — HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

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MCGH0025

10A

Page of

MACON COUNTY GENERAL HOSPITAL — STANDARD Continuation Sheet

Time	BP/ cap.refill	P	R	T	O2 Sat	IN / site	OUT/ site	Meds/Titrated Infusions/Procedures	NARRATIVE	PL	INI
0810									ETT placement checked BBS		
									husband present @ bedside.		
									IVF placed in ca. —— ne		
0811	82/47	72	BM	96.3	ⓔ 100%		↓		Dr. Chunn giving report to		
									VUMC Lifeflight. —— ne		
									Dr. McFerson accepted. —— ne		
0818	71/52	67	Bm		100%				Daughter @ bedside. —— ne		
0829									VUMC Lifeflight present for		
									transport. ne		
0844									Pt. transported to VUMC		
									per Lifeflight —— ne		
0904									report to cath lab charge		
									nurse ——		ce
								:TOTALS	see continuation sheet ☐		

ALLERGIES:

I & O Legend: Chest tube #1= CT1, Chest tube #2= CT2, Foley = F, Void = V, Emesis = E, NasoGastric tube = NG, Oral gastric tube = OG, Oral = O

other:

Physician Signature:

SIGNATURE	INI
Nicole Carver, RN	ne
W. [illegible]	NS

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

Form #10A © ENDS © 4/2000, rev. 12/29/01

MCGH0026

RESUSCITATION FLOW SHEET

DATE: 5-31-11 TIME: 0716 LOCATION: ER

NURSE: W Steen RN T Deering N. Carmer

PHYSICIANS PRESENT: T. Phillips CRN Chunn

ANCILLARY: Lab RT X-ray

TYPE OF ARREST: (All Appropriate)

- [x] RESPIRATORY
- [x] CARDIAC
- [x] WITNESSED
- [ ] UNWITNESSED

ADDITIONAL TEAM MEMBERS

EMS Earl Cunningham EMT-P
Jimmy Barlow EMT-P
D. Smith EMT-IV

Time Family Notified:

Time Attend. Phys. Notified:

INTUBATION

SIZE: 7.0

TIME: PTA # OF ATTEMPTS

BY WHOM: J. Barlow EMT-P

BILATERAL BREATH SOUNDS [x] PRESENT [ ] ABSENT

EID USED: [ ] YES [ ] NO

RHYTHM CODES:

A — Asystole
VF — V. Fib
VT — V. Tach
PEA — Pulseless Electrical Activity

IV PRESENT IV STARTED

NEEDLE SIZE: 20g (L) hand

SOLUTION: NS by ems

BY WHOM:

TIME:	Airway Oral-ET	Respirations A=Assisted S=Spontaneous	Pulse P=Present PWC=Pulse W/CPR	Blood Pressure	Rhythm/Rate See Code	CPR M=Maintained S=Stopped	Defibrillated Watt/Seconds	External Pacer	Epinephrine	Atropine	Lidocaine Bolus / Lidocaine Drip 2gm/500cc D5W	Bretylium Bolus / Bretylium Drip 2gm/500 D5W	Procainamide Bolus / Procainamide Drip 2gm/500 NS	Mag Sulfate	Sodium Bicarb	Dopamine 800mg/500 D5W	Amiodarone	Vasopressin
0716	ETT	A	PWC		VF	M	150j											
0720	ETT	A	P	111/88	SR	S			1mg									
0728	ETT	A	P	80/37	VT	S			0725									
0734	ETT	A	PWC		Bigeminy	M												
0735	ETT	A	P		SR PVC's	S									[illegible]	10mcg kg min		
1740 (5-31-11) ~~0739~~	ETT	A	PWC		SR PVC's	M			1mg									
0754	ETT	A	P		SR	S										15mcg kg min		
0755	ETT	A	P	64/45	SR	S			0.5mg									
							see nurses notes											

OUTCOME: [x] SUCCESSFUL DISPOSITION: Vanderbilt Cardiac cath lab

UNSUCCESSFUL:

PRONOUNCED DEAD AT ______ (TIME)

BY WHOM:

VALUABLES - LIST/GIVEN TO: NONE

SIGNATURES: [signature]

PHYSICIAN

W Steen RN

RECORDER

White Copy - Chart Canary Copy - Pharmacy Pink Copy - Nursing

MACON COUNTY GENERAL HOSPITAL
CONSENT TO TRANSFER

Under government regulations you have certain rights to health care before being transferred to another facility. We are required to inform you, or if you are not able to understand these rights, a family member of these rights before transferring you to another facility. Also, you or a family member are to be notified of the risk that may be involved in transferring or not transferring to another hospital.

IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR, YOU HAVE THE RIGHT TO RECEIVE, WITHIN THE CAPABILITIES OF THIS HOSPITAL'S STAFF AND FACILITIES:

*An appropriate MEDICAL SCREENING EXAMINATION
*Necessary STABILIZATION TREATMENT(including treatment for an unborn child) and if necessary:
*An appropriate TRANSFER to another facility even if:

YOU CAN NOT PAY OR DO NOT HAVE MEDICAL INSURANCE or YOU ARE NOT ENTITLED TO MEDICARE or MEDICAID

PATIENT'S NAME: Cherry Pamela. Date of Birth: 6/14/52 Date: 5/31/11 Time: 0755

TRANSFERRING PHYSICIAN: Chunn.

RECEIVING HOSPITAL/PHYSICIAN: VUMC / Dr. McPherson

REASON FOR TRANSFER: ☑ Patient required treatment not provided by MCGH ☐ Patient/guardian requests transfer
☐ Other:

RISK OF TRANSFER: ☐ Traffic delay ☑ Accident during transport ☑ Inclement weather
☑ Worsening of condition ☑ Cardiopulmonary arrest ☐ Other:

REPORT CALLED TO: Life flight. BY: Dr. Chunn TIME: 0805

VITAL SIGNS: BP 71 82/49 P 88 Resp intubated T 96.8(e) O2 SAT 100 % ☐ RA ☐ O2 @ 100%
COPY OF MEDICAL RECORD ACCOMPANIED PT: ☑ YES ☐ NO ☑ Patient Home Med List Sent
METHOD OF TRANSFER: ☑ Helicopter ☐ Ambulance (☐ ALS ☐ BLS) ☐ Private Car

I, Pamela Cherry. , have been informed of my rights, risks and benefits of transfer and ✓ DO _____ DO NOT agree to the transfer.

PATIENT SIGNATURE

PATIENT REPRESENTATIVE SIGNATURE

WITNESS

PHYSICIAN SIGNATURE

CONDITION AT TRANSFER: ☐ STABLE ☑ UNSTABLE, stabilized within our facility's capabilities (See Physician Certificate for Transfer)

PHYSICIAN CERTIFICATE FOR TRANSFER:(Required if unstable patient transferred)

I hereby certify that based on the information available to me at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical care at another facility outweighs the increased risk to the patient and, in the case of labor, to the unborn child, from effecting the transfer. This certification is based upon the following (check, if appropriate, at least one benefit must be noted):

BENEFITS: _____ SPECIALIZED CARE (describe): Transfer at request of family and needy cardiac expertise

_____ OTHER:

Date: _____ Time: _____ Physician Signature:

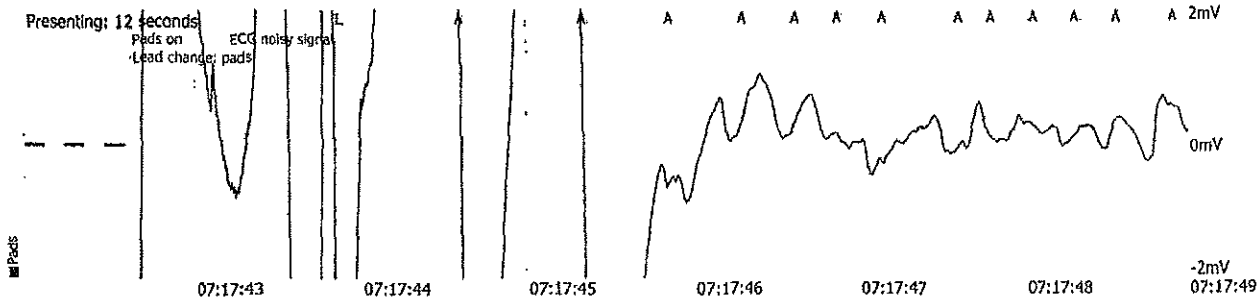
MCGH-108 Rev 01/09

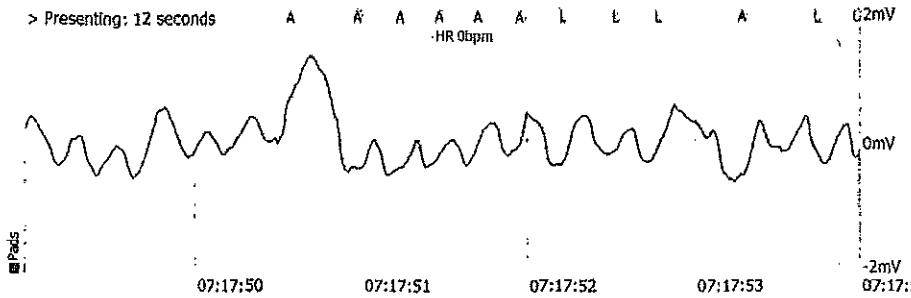
CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

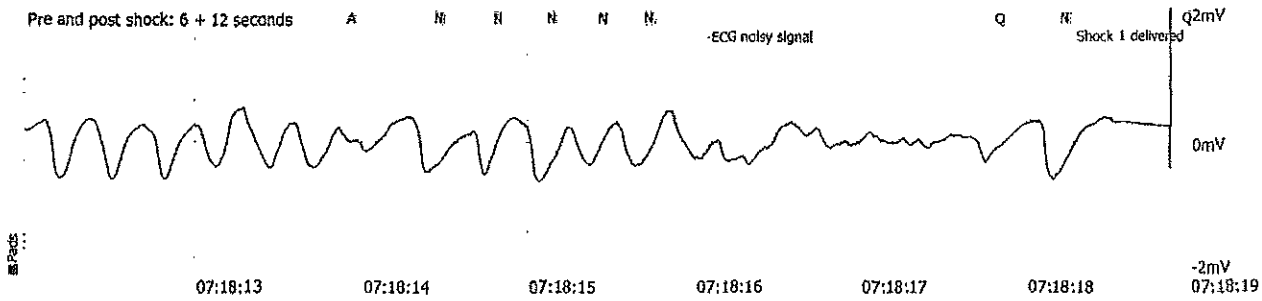
ECG Pre- and Post-shock

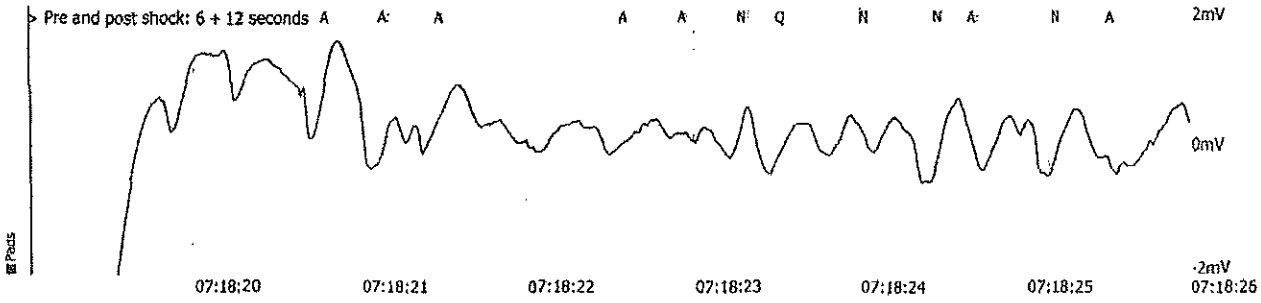
HEARTSTART
Event Review Pro / Hospital 4.1

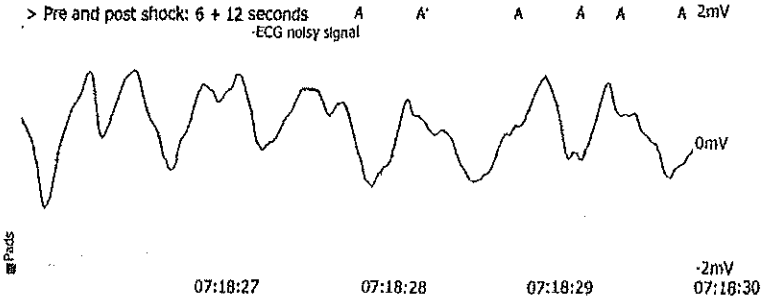
Case ID:	110531071245552f6	**Patient ID:**	06141952
Case date:	5/31/2011	**First name:**	PAMELA
Device:	HeartStart MRx: US00540164	**Last name:**	CHERRY







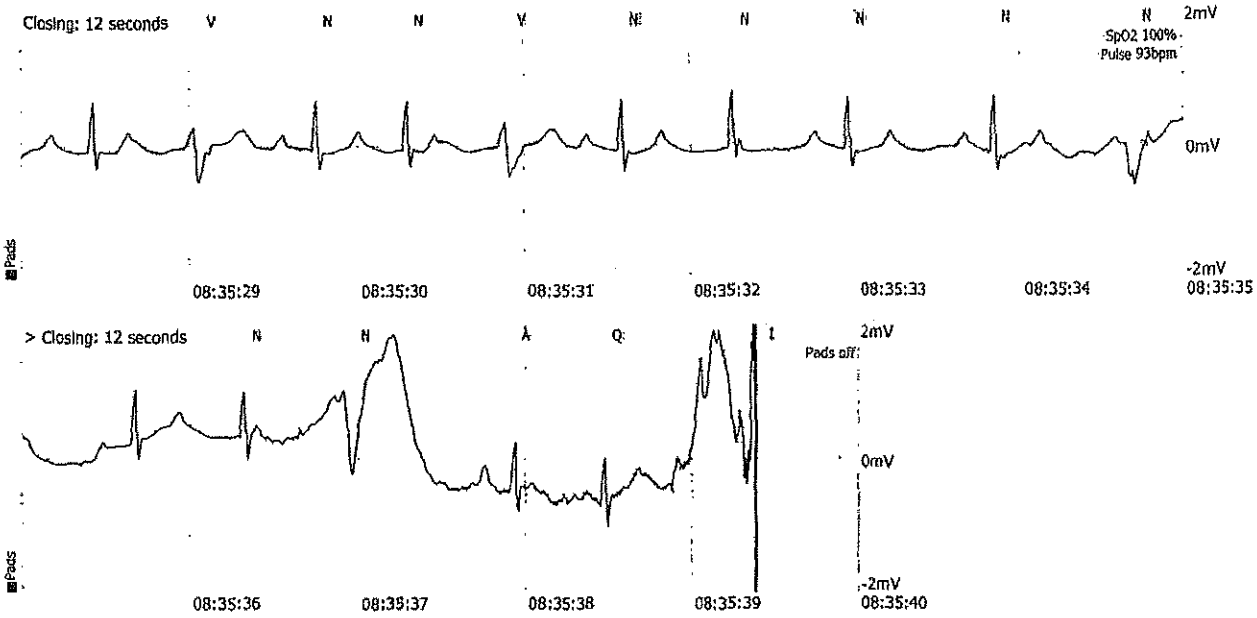




ECG Pre- and Post-shock

HEARTSTART
Event Review Pro / Hospital 4.1

Case ID:	1105310712455 2f6	**Patient ID:**	06141952
Case date:	5/31/2011	**First name:**	PAMELA
Device:	HeartStart MRx: US00540164	**Last name:**	CHERRY



Vital Trends

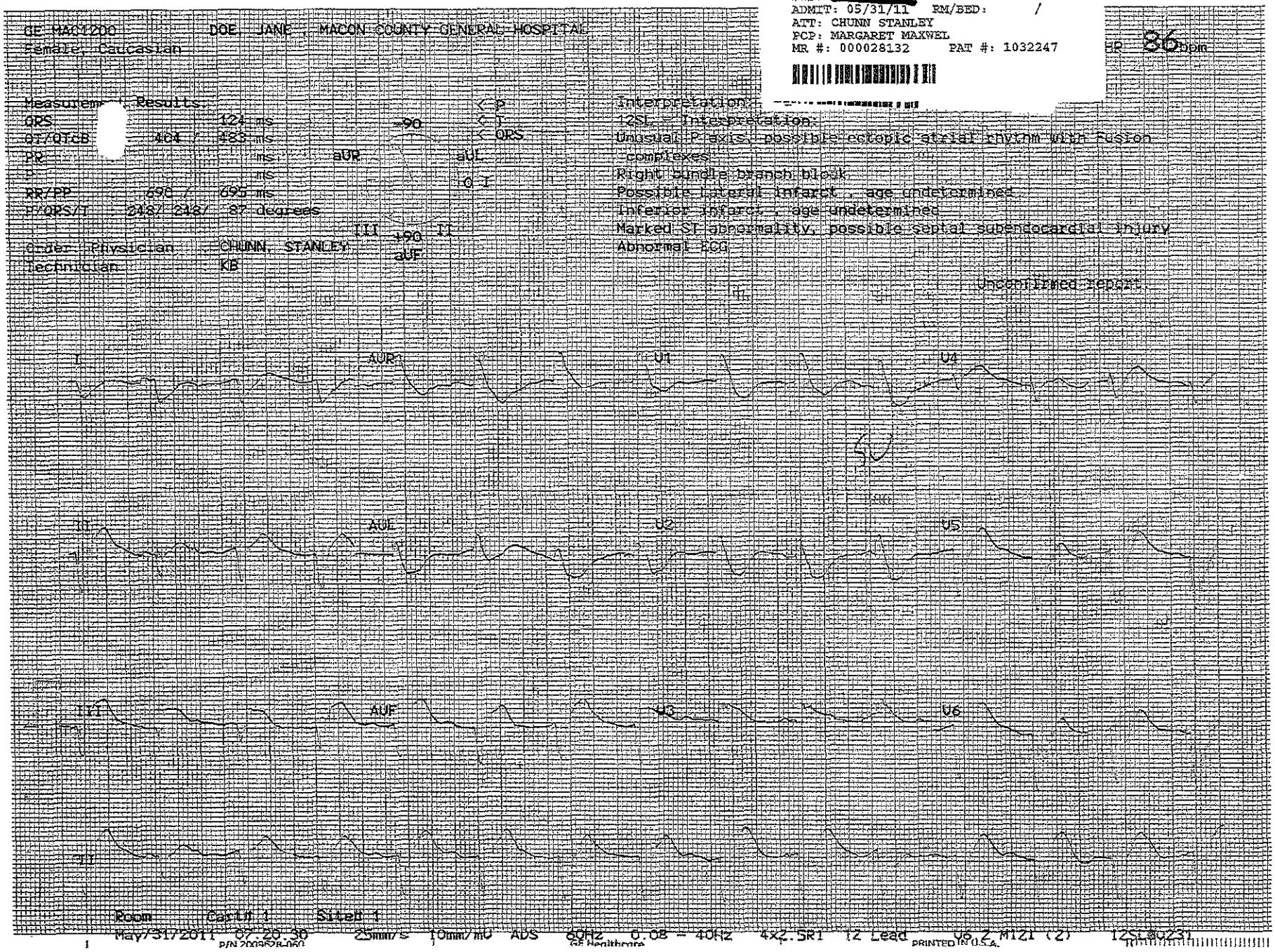
HEARTSTART
Event Review Pro / Hospital 4.1

Case ID:	1105310712455 2f6	**Patient ID:**	06141952
Case date:	5/31/2011	**First name:**	PAMELA
Device:	HeartStart MRx: US00540164	**Last name:**	CHERRY

Vital Trend	07:12:00	07:17:00	07:22:00	07:27:00	07:32:00	07:37:00	07:42:00	07:47:00
HR (bpm)	--	--	121^	98^	115^	80^	50^	123^
NBP systolic (mmHg)	--	--	111^	80^	86	89^	146^	142^
NBP diastolic (mmHg)	--	--	88^	37^	66	66^	113^	82^
NBP mean (mmHg)	--	--	96^	51^	73	74^	124^	102^
EtCO2 (mmHg)	--	--	24^	23^	27^	20^	34^	35^
AwRR (rpm)	--	--	13^	14^	14^	12^	15^	12^
SpO2 (%)	--	--	90	100^	--	--	98^	100^
Pulse (bpm)	--	--	111	106^	--	--	49^	138^

Vital Trend	07:52:00	07:57:00	08:02:00	08:07:00	08:12:00	08:17:00	08:22:00	08:27:00
HR (bpm)	94^	77^	137^	80^	80^	76^	81^	86^
NBP systolic (mmHg)	66^	62^	134^	72^	82	82^	71	158^
NBP diastolic (mmHg)	46^	45^	83^	48^	67	65^	52	129^
NBP mean (mmHg)	53^	51^	100^	56^	72	71^	58	139^
EtCO2 (mmHg)	29^	27^	38^	35^	32^	32^	33^	33^
AwRR (rpm)	13^	11^	7^	10^	9^	10^	9^	10^
SpO2 (%)	99^	94^	100^	100^	100^	100^	100^	100^
Pulse (bpm)	86^	68^	136^	58^	79^	61^	77^	77^

Vital Trend	08:32:00	08:37:00	08:42:00	08:47:00	08:52:00	08:57:00	09:02:00	09:07:00
HR (bpm)	91^	--	--	--	--	--	--	--
NBP systolic (mmHg)	78^	75	--	--	--	--	--	--
NBP diastolic (mmHg)	57^	53	--	--	--	--	--	--
NBP mean (mmHg)	64^	60	--	--	--	--	--	--
EtCO2 (mmHg)	35^	31^	--	--	--	--	--	--
AwRR (rpm)	13^	12^	--	--	--	--	--	--
SpO2 (%)	100^	--	--	--	--	--	--	--
Pulse (bpm)	43^	--	--	--	--	--	--	--



MACON COUNTY GENERAL HOSPITAL
204 MEDICAL DRIVE
LAFAYETTE, TN 37083

RADIOLOGY REPORT

PATIENT: CHERRY PAMELA J DATE: 05-31-2011

SERVICE TYPE: EMR ROOM: MR# 28136

ORDERING PROVIDER: CHUNN STANLEY DOB: [redacted]

PRIMARY PROVIDER: ACCT# 1032247

REASON FOR EXAMINATION: CPR in progress

SINGLE-VIEW CHEST
Endotracheal tube has been placed. The tip is in good position. No consolidation or pleural effusion is identified. Heart size is normal. No bone destruction is identified.

CONCLUSION: Endotracheal intubation without pulmonary infiltrate, pleural effusion, pneumothorax, or cardiomediastinal finding.

T: dlc 2011-05-31 12:27:25
D: Kraft, William 2011-05-31 07:39:49

Electronically Signed By: KRAFT WILLIAM L 2011-05-31 14:17:57

MACON COUNTY GENERAL HOSPITAL
P.O. BOX 378
LAFAYETTE TN 37083

LABORATORY CLIA#44D0307212
JULIE LEMMON, M.D.

Name: **CHERRY PAMELA J** Status: O/P / EMR Adm Date: **5/31/11**
Pat#: 1032247 DOB: [redacted] Adm Phys: CHUNN STANLEY
Strt: 5/31/11 7:31 Age/Sex: 58 / F Ord Phys: CHUNN STANLEY
Ord#: R 300 400 500 600 MR#: 000028132 Fam Phys: MARGARET MAXWEL
700

Special Instructions:
Reported: 5/31/11 8:23

Test Name	Result	Flag	Reference Range	Units
Collected: 5/31/11 7:32 SC Received: 5/31/11 7:32 RL Verified: 5/31/11 7:34 RL				
CBC WITH AUTO DIFF				
WBC COUNT AUTO	14.6	H	4.8 - 10.8	10^3/mcL
RED BLOOD CELL	3.31	L	4.20 - 5.40	10^6/mcL
HEMOGLOBIN	11.2	L	12.0 - 16.0	G/dL
HEMATOCRIT	33.6	L	37.0 - 47.0	%
MCV	101.4	H	81.0 - 99.0	FL
MCH	33.8	H	27.0 - 31.0	pg
MCHC	33.3		32.0 - 36.0	g/dL
RDW	14.0		11.5 - 15.5	%
PLATELET COUNT AUTO	201		130 - 400	10^3/mcL
MEAN PLATELET VOLUME	7.6		7.4 - 10.4	fL
NEUTROPHIL %	40.7	L	50.0 - 75.0	%
LYMPHOCYTE %	49.2	H	20.5 - 45.5	%
MONOCYTE %	6.2		5.5 - 11.7	%
EOSINOPHIL %	1.4		0.9 - 2.9	%
BASOPHIL %	2.5	H	0.2 - 1.0	%
NEUTROPHIL ABSOLUTE #	5.9	H	2.2 - 4.8	10^3/mcL
LYMPHOCYTE ABSOLUTE #	7.2	H	1.3 - 2.9	10^3/mcL
MONOCYTE ABSOLUTE #	0.9	H	0.3 - 0.8	10^3/mcL
EOSINOPHIL ABSOLUTE #	0.2		0.0 - 0.2	10^3/mcL
BASOPHIL ABSOLUTE #	0.4	H	0.0 - 0.1	10^3/mcL
MANUAL DIFFERENTIAL			--------	-------
Collected: 5/31/11 7:32 SC Received: 5/31/11 7:32 RL Verified: 5/31/11 8:23 DH				
BASIC METABOLIC PANEL				
GLUCOSE	424	H	70 - 110	mg/dL
BLOOD UREA NITROGEN	15		7 - 18	mg/dL
CREATININE	1.4	H	0.6 - 1.3	mg/dL
BUN/CREATININE RATIO	10.7		6.0 - 20.0	
GFR	39	L	60	ml/min/1.73m2
SODIUM	137		136 - 145	mmol/L
POTASSIUM	3.9		3.5 - 5.1	mmol/L
CHLORIDE	102		98 - 107	mmol/L
CARBON DIOXIDE	17.2	L	21.0 - 32.0	mmol/L

Continue ...

MACON COUNTY GENERAL HOSPITAL
P.O. BOX 378
LAFAYETTE TN 37083

LABORATORY CLIA#44D0307212
JULIE LEMMON, M.D.

Name: **CHERRY PAMELA J** Status: O/P / EMR Adm Date: **5/31/11**
Pat#: 1032247 DOB: [redacted] Adm Phys: CHUNN STANLEY
Strt: 5/31/11 7:31 Age/Sex: 58 / F Ord Phys: CHUNN STANLEY
Ord#: R 300 400 500 600 MR#: 000028132 Fam Phys: MARGARET MAXWEL
700

Special Instructions:
Reported: 5/31/11 8:23

Test Name	Result	Flag	Reference Range	Units
ANION GAP	21.7	H	10.0 - 18.0	mmol/L
CALCIUM	7.7	L	8.5 - 10.1	mg/dL
OSMOLALITY CALCULATED	293		275 - 295	mOsm/L
Collected: 5/31/11 7:32 SC Received: 5/31/11 7:32 RL Verified: 5/31/11 8:23 DH				
CK MB				
CK MB	159.5	H	0.0 - 3.6	ng/mL
Collected: 5/31/11 7:32 SC Received: 5/31/11 7:32 RL Verified: 5/31/11 8:23 DH				
MAGNESIUM	2.4		1.8 - 2.4	mg/dL
Collected: 5/31/11 7:32 SC Received: 5/31/11 7:32 RL Verified: 5/31/11 8:23 DH				
TROPONIN-I	13.90	H	0.00 - 0.10	ng/mL

MACON COUNTY GENERAL HOSPITAL
P.O. BOX 378
LAFAYETTE TN 37083

RESPIRATORY THERAPY
JULIE LEMMON, M.D.

Name: CHERRY PAMELA J
Pat#: 1032247
Strt: 5/31/11 8:01
Ord#: R 900

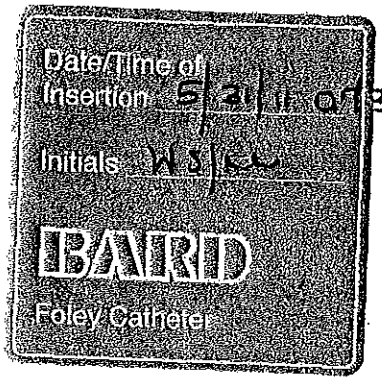
Status: O/P / EMR
DOB: [redacted]
Age/Sex: 58 / F
MR#: 000028132

Adm Date: 5/31/11
Adm Phys: CHUNN STANLEY
Ord Phys: CHUNN STANLEY
Fam Phys: MARGARET MAXWEL

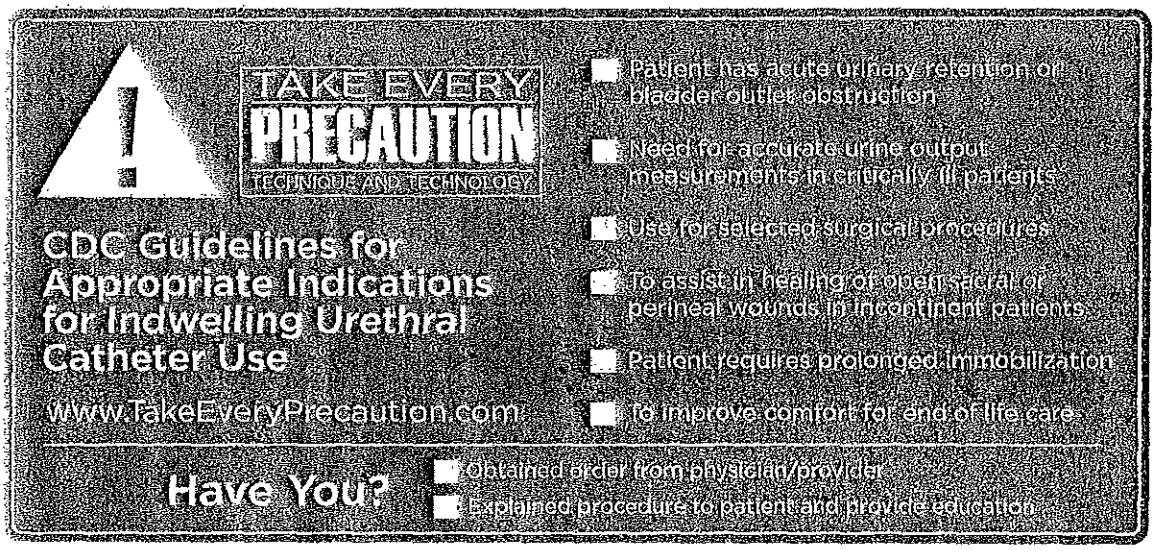
Special Instructions:
Reported: 5/31/11 8:04

Test Name	Result	Flag	Reference Range	Units
Collected: 5/31/11 7:30 SC Received: 5/31/11 7:32 KB Verified: 5/31/11 8:04 KB				
ARTERIAL BLOOD GAS				
PH	6.98	CL	7.35 - 7.45	
PCO2	39		35 - 45	mmHg
PO2	348	H	80 - 100	mmHg
HCO3	9	L	22 - 26	mmol/L
BE	-22	L	-2 - +2	mmol/L
O2 SATURATION	100		95 - 100	%
SITE	RT FEMORAL			
DEVICE	AMBU BAG			
OXYGEN	15			L/minute
# OF ATTEMPTS	1		1 - 5	
PRESSURE HELD TO SITE	5			minutes

CRITICAL VALUE RESPONSE:
5/31/11 8:03 ABG KENDRA BRANSFORD notified Dr chunn
on 5/31/11 at 08:03
Critical value phoned and read back.



CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247



Celina Fire / EMS

HANDOFF REPORT

211 Green Street • P.O. Box 449
Celina, Tennessee 38551
Phone: (931) 243-3147
Fax: (931) 243-4969

Comp.# ______ /Log # ______ Dispatch Info: Unresponsive (no pulse) AMA ☐ HOSPICE ☐

Crew: S Barlow / S Philpot

PICK-UP: Res. ... of Family SK ☐ EMER ☐ DOCTOR Unknown

DEST: MCG SK ☐ EMER ☐ DOCTOR Chunn

PATIENT NAME Pamela S Cherry

ADDRESS [redacted]

CITY [redacted] STATE [redacted] ZIP 46203

PHONE (317) 683 - 4716

SOCIAL SECURITY NO. ______

DATE OF BIRTH [redacted] AGE 58

RACE C SEX Female WEIGHT ______ lbs.

INSURANCE: ______

INS # ______ CARD COPIES: ☐ YES ☐ NO

UNIT I.D. 58

DATE OF SERVICE 5/31/11

RECEIVED	ARRIVAL PT
DISPATCHED	DEPARTURE
ENROUTE	DESTINATION
ARRIVAL	AVAILABLE

MILEAGE

START ______
SCENE ______
DESTINATION ______
TOTAL ______

PARAMEDIC ASSESSMENT PERFORMED ☑ YES ☐ NO

CHIEF COMPLAINT: Unresponsive

ALLERGIES: NKA

PAST HX: Unknown

MEDS: Unknown

MVC
PT. SEAT BELT ☐ YES ☐ NO ☐ Unknown

AIR BAG ☐ YES ☐ NO

PT LOCATION: D C FP / RP RC RP

PMS OS + ______ OA + ______

02 / AIRWAY THERAPY

RATE	MODE
BVM 15 L	Mask ☐ NC ☐
	Mask ☐ NC ☐

TIME	TYPE	SIZE	OS	OA
	OET			
	NET			
	COMB			

SUCTION: ☑ YES ☐ NO

LOC	Unresp
Airway	Open
Respirations	0
Pulse	None
B.P.	0 / 0
SPO2	—%
EtCO2	mm/hg
Pupil Size	R mm L mm
Pupil Response	R: + L: Non R

TIME	MEDS / FLUIDS / VITALS	MODE	DOSE / RATE	RT / GA	SITE	PTA	M-T
06:48	CPR	BVM	Ventilation	NS			
06:50	Intubated	7.0	Tube	23 cm	at	Lips	
06:52	IV NSR	EPI	IVP				
06:53	ATP	IVP					
06:56	EPI	IVP	Shocked	6 Times			En Route
07:04	ATP	IVP					
07:08	EPI	IVP	(07:14) TEA	at ER			
07:13	EPI	IVP					

Current HX / MOI: Responsive

TREATMENT:

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

GLASCOW COMA SCALE

EYE OPENING	Spontaneous	4	
	To Voice	3	
	To Pain	2	
	None	1	1
VERBAL RESPONSE	Oriented	5	
	Confused	4	
	Inappropriate Words	3	
	Garbled	2	
	None	1	1
MOTOR RESPONSE	Obeys Command	6	
	Localized Pain	5	
	Withdraw (Pain)	4	
	Flexion (Pain)	3	
	Extension (Pain)	2	
	None	1	1
Glascow Coma Score Total			3

REVISED TRAUMA SCORE

A. RESPIRATORY RATE	10 - 29	4
	> 29	3
	6 - 9	2
	1 - 5	1
	0	0
B. SYSTOLIC B.P.	> 89	4
	76 - 89	3
	50 - 75	2
	1 - 49	1
	0	0
C. GLASCOW COMA SCORE	13 - 15	4
	9 - 12	3
	6 - 8	2
	4 - 5	1
	3	0

REVISED TRAUMA SCORE TOTAL

1) I AUTHORIZE ... ABOUT ME TO ... AND HEALTH C... ARIES OR CAR... LATED MEDICA... TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

2) BY MY SIGNATURE OR THAT OF MY AUTHORIZED AGENT, I SHOW THAT I HAVE RECEIVED THE CELINA FIRE AND EMS HIPPA PRIVACY POLICY NOTICE.

3) ☐ IF THIS BLOCK IS CHECKED, THE PATIENT IS UNABLE TO SIGN AND/OR DID NOT HAVE A RESPONSIBLE PARTY PRESENT WHEN SERVICE WAS RENDERED AND/OR THE PATIENT WAS MENTALLY UNABLE TO UNDERSTAND THE FINANCIAL RESPONSIBILITY SECTION OF THIS AGREEMENT.

SIGNATURE OF PATIENT: PWS DATE SIGNED: 05-31-11

REASON UNABLE TO SIGN: Unresponsive

Witness: [signature]

[signature] EMT /EMT-P

[signature] RECEIVING SIGNATURE

PHYSICIAN ORDERS AUTHORIZATION

AFTERCARE INSTRUCTIONS TO PATIENTS

The examination and treatment you have received in the Emergency Department has been rendered on an EMERGENCY basis ONLY and is not intended to be as substitute for an effort to provide COMPLETE medical care. Your listed family physician will be provided with a copy of this visit for continuity of your care. It is important that you let him check you again and that you report to him any new or remaining problems at that time. This is necessary because it is IMPOSSIBLE to recognize and treat ALL elements of illness or injury in a single Emergency Department visit. Meanwhile FOLLOW THE INSTRUCTIONS INDICATED FOR YOU BELOW.

SPRAIN, FRACTURE AND SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours. Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times. Wait 24 hours for the cast to become strong before you allow pressure or weight on any part of the cast.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast- this should be done often if it does not cause pain.
- ☐ If the part swells anyway, or gets cold, blue or numb, or pain increases markedly, have it checked promptly.

BACK OR NECK INJURY INSTRUCTIONS

- ☐ Use heat or cold on the injured area - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movements that make pain worse.
- ☐ Relax emotionally - If you are tense, the problem will only be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps clear soreness.

WOUND CARE (CUTS, ABRASIONS, BURNS, ETC.)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus, or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Clean stitches with Peroxide or Betadine Solution, then apply Neosporin Ointment and bandage.
- ☐ Dressings should be changed in _____ days.
  - ☐ Change them.
  - ☐ Call and see your doctor.
- ☐ Tetanus Toxoid given. _____

FOLLOW - UP INSTRUCTIONS

- ☐ Call to arrange an appointment at his office to see Dr. _____ in ___ days for follow-up care. **Call sooner if you think necessary.** His phone. _____.

HEAD INJURY INSTRUCTIONS

Report to your doctor immediately if anything listed occurs (even within several months.)

- ☐ Persistent vomiting, stiff neck, fever.
- ☐ Unequal pupils (one pupil large, one small).
- ☐ Confusion or unusual drowsiness.
- ☐ Convulsions or unconsciousness.
- ☐ Stumbling or other problems with normal use of arms or legs, or areas of skin numbness.

NOTE: Wake patient hourly the first night to check for these signs.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by the Radiology Dept. If any abnormalities are found that have not been called to your attention; your doctor will be notified. (Please be certain that the Emergency Dept. has the name of your family doctor.)

Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken.

GENERAL INSTRUCTIONS

- ☐ Stay in bed / may go to the bathroom.
- ☐ Use vaporizer.
- ☐ Take clear liquids by mouth until nausea, vomiting, diarrhea and abdominal cramps subside, then gradually return to normal diet.
- ☐ Drink large amounts of liquid.
- ☐ Take _____ Tylenol every 4 hours. Stop after 48 hours.
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ No weight bearing, use crutches.
- ☐ Fill prescriptions given to you from Emergency Dept. and take as directed.
- ☐ Warm soaks to area 4 times daily, 20 to 40 minutes each time.
- ☐ Stop smoking
- ☐ Fever control instructions given.
- ☐ Do not drive or operate machinery while taking medication, _____
- ☐ Apply ice packs to area.
- ☐ Wear eye patch for _____ hours.
- ☐ See patient home medication list.
- ☐ Post sedation / pain mediation instructions.

ADDITIONAL INSTRUCTIONS / EDUCATIONAL HANDOUTS: _____

I hereby acknowledge receipt of all the instructions as indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my condition worsens or if new symptoms appear, I should contact my Doctor immediately, or if unable to reach my doctor, return to the Emergency Room. I understand that if I receive a medication to take home with me, it may not be in a childproof container and I am assuming responsibility for safe storage.

PATIENT OR GUARDIAN SIGNATURE	DATE	WITNESS SIGNATURE

CHERRY PAMELA J HSV: EMR
DOB [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

MCGH Phone: 666-2147

134032

MACON COUNTY GENERAL HOSPITAL
P O BOX 378
LAFAYETTE, TN 3708[illegible]
615-666-2147

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

NOTICE TO OUR PATIENTS AND/OR THEIR REPRESENTATIVE

In order to be able to offer the healthcare services needed by our community, Macon County General Hospital has contracted with independent contractors who have been granted the privilege of using the facilities at Macon County General hospital for the care and treatment of their patients. However, they are ***NOT*** employed by the hospital. Organizations and/or individuals that will provide services and/or patient care in Macon County General Hospital facilities and will generate a separate bill include but are not limited to;

- PICC Line Insertion
- Anesthesia
- Surgeons
- ER Physicians
- Radiologist
- Pathologist
- Physicians seeing patients in Specialty Clinic
- Podiatrist
- Cardiologist
- Gastroenterologist
- Ophthalmologist
- Dentist
- Orthopedics
- Ambulance/Helicopter Services

If you have any questions about these arrangements, please ask a registration specialist for assistance.

If you have any questions about these separate bills, please call the number on the bill.

The above information has been explained to me and I understand that the above organization/individuals are not employees of Macon County General Hospital and that I will be billed separately for the services of any of the above groups.

Patient's Signature — Date

Pamela J Cherry — 5-31-11

Representative's Signature — Date

MAC-265 Rev. 12-09 Reorder from Two Point Inc. 1-800-800-5876

MACON COUNTY GENERAL HOSPITAL
Lafayette, Tennessee 37083

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

Patient Name ___

1. Authorization for Treatment: This is to certify that I (we) the undersigned request treatment a[illegible] treatments considered necessary for the patient whose name appears below. I voluntarily consent to the rendering [illegible] employees and authorized agents of MCGH as deemed necessary or beneficial in their professional judgment. I acknow[illegible] extent of such examination or treatment of my condition. I understand that as part of my healthcare, MCGH originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment and any plans for further care or treatment. I understand that this information will be used by hospital employees as a basis for planning my care and treatment, and as a means of communication among the healthcare professionals who contribute to my care. I realize that copies of this visit may be forwarded to my listed attending physician for continuity of care; and I understand that it may be necessary for MCGH or my attending physician to make available to other healthcare providers, copies of my medical records for information relating to my care for follow-up or continued care. I understand that I must instruct MCGH otherwise if I wish copies of this visit NOT to be forwarded to my attending physician or other healthcare providers. **Authorization is hereby granted for such treatment and procedures.**
- For ER Patients Only: I(we) understand that a personal physician is to be selected by or on behalf of the patient within 24 hours of hospitalization if further treatment is required or immediately if complications arise.

2. Assignment of Insurance Benefits and Release of Information: I hereby authorize payment directly to MCGH for entitled benefits arising out of any policy of insurance insuring patient or any other party liable to patient and hereby assign any group, individual, Medicare and/or Medicaid payment due me to Macon County General Hospital benefit for application on patient's bill. I also authorize the Hospital to transfer any overpayment to other accounts for which I am responsible. Furthermore, I agree that if my case is handled under the Workers Compensation Act the agent is hereby authorized to have access to, or request copies of my hospital record. I also authorize payment directly to all Physicians, Radiologist, Pathologist, and Anesthesiologist performing services to me or for me through MCGH of all benefits which may be due and payable under insurance coverage that I may have I hereby authorize MCGH and physicians to furnish any medical information and/or copies of my hospital record as requested by insurance companies with whom I have coverage. A carbon or photostatic copy of this signature shall be considered as valid as the original. **Medicare-Medicaid Patient's Certification:** I certify that the information given by me in applying for payment under Titles XVIII and/or XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

3. Financial Agreement and Payment Guarantee: For and in consideration of the services rendered to the patient by MCGH, I (we) do hereby guarantee payment of all charges incurred to the account of the named patient from time of admission until discharge. I (we) the undersigned agree to pay reasonable attorney's fees and collection expenses associated with this account should it be referred to an attorney for collection.

4. Waiver of Hospital Responsibility for Patient Valuables: MCGH will endeavor to take all necessary precautions to safeguard personal articles and valuables of patients being treated at the hospital; however MCGH shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, coats or other articles brought to the hospital. I understand all personal property must be collected at the time of discharge from the hospital.

5. Infection Control Consent: To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient at MCGH. If, for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. These results will be kept confidential as provided by Tennessee State Law.

6. Patient Rights and Responsibilities:
Do you currently have Hospice? No ✓ Yes_____ (agency)_____
Do you currently have Home Health? No ✓ Yes_____ (agency)_____
I have been offered a copy of the **Patient Rights and Responsibilities.** X DLC (initials)

7. Privacy Notice Acknowledgement: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. By initiating the line below, you acknowledge your receipt of our Notice of Privacy Practices.
I have received a copy of Macon County General Hospital's **Notice of Privacy Practices.** X DLC (initials)

8. Appointment Reminders and Follow-up Calls: I give my consent for MCGH to leave a message or voice mail in reference to my hospital visit for items such as appointment reminders, insurance items, and/or test results. X_____ (initials) Phone number:_____

9. Advance Directives:
Do you have a **Durable Power of Attorney for Healthcare?** No ✓ Yes_____ (name)_____ (phone)_____
Do you have a **Living Will?** No ✓ Yes_____
If Yes, is a copy available? No_____ Yes_____ If copy not available, content of advanced directives includes:_____

10. Request for Private Room: In the event that I am admitted, I would like to request a **Private Room**, if available? X_____ (initials)

11. Patient Directory:
I hereby give permission to MCGH to include my name, location within the hospital, and general condition (good, fair, stable) to the following:

✓ Anyone who inquires
_____ **DO NOT** include in Directory

During my stay in the hospital, I hereby give permission to MCGH to share my general condition and details of my care with the following people.

Name Relationship

Name Relationship

X_____
Patient's Signature Date

X David Chunn
Guardian if Minor/Authorized Person Relationship

X [illegible] 5-31-11
Witness Date

TELEPHONE PERMISSION FOR TREATMENT

This patient is an unemancipated minor _____ years of age, and unable to sign for treatment. Telephone consent is given on the patient's behalf by:

Name of Representative Relationship

1st Witness of Telephone Call Date & Time

2nd Witness of Telephone Call Date & Time

REFUSAL OF TREATMENT – MEDICAL SCREENING – DISCHARGE AGAINST MEDICAL ADVICE

This is to certify that I,_____, have refused medical care and treatment and am leaving MCGH against medical advice of the attending physician and the hospital staff. I acknowledge that I have been informed of the risk(s) involved, which include:_____ and hereby release all concerned (physician, hospital, and employees) from all responsibility and any ill effects which may result from my action.

Signed

Witness Date

[redacted]

CHERRY PAMELA J HSV: EMR
DOB: [redacted] AGE: 58 SEX: F
ADMIT: 05/31/11 RM/BED: /
ATT: CHUNN STANLEY
PCP: MARGARET MAXWEL
MR #: 000028132 PAT #: 1032247

Vanderbilt LifeFlight
Vanderbilt Medical Center
Skyport Helipad - VUH
Nashville, TN 37232-7430

Business: 615.936.0770
Fax: 615.936.0772
Communications: 615.322.3211
Flight Request: 1.800.288.8111
www.vulifeflight.com

Date: 5/31/11

Dear Colleagues:

Thank you for requesting Vanderbilt LifeFlight to provide air medical transport for your patient. Vanderbilt LifeFlight is currently conducting a post-flight customer service survey on all of our missions. LifeFlight is asking each referring facility/agency to provide feedback on the transfer experience. Your cooperation would help us tremendously to provide better customer service in the fut: .e. It will only take a couple of minutes to complete the on-line survey.

Please go to www.vulifeflight.com Click on the icon for the ***On-Line Feedback Form*** in the top right margin of the page.

Flight crew: Wilson MATTHEWS MORRIS

Flight Number: 823

Thanks in advance for your participation in our survey.

Sincerely,

W. Matthews

Flight Crew Member

***Vanderbilt LifeFlight is committed to assisting you with equipment returns. If you have sent a piece of equipment with LifeFlight (e.g. spinal immobilization) you may send an e-mail to EMSEquipment@Vanderbilt.edu This will alert the staff that your service or hospital has equipment needing to be returned. ***

Physician Certification Statement
Medical Necessity for Air Medical Transport

Please give completed form to flightcrew

Flight# _____ *MR#* _____

Date: 5-31-11 Patient Name: Cherry, Paula Diagnosis: Cardiopulmonary Arrest

Presenting time critical condition / required intervention: 911 Call

The following information is required for INTERFACILITY TRANSPORTS:

As the attending physician for *(enter patient name)* Paula Cherry,

at *(enter referring hospital name)* Macon Co. General, I am directing

emergency transportation to the services of *(enter receiving physician name)* Dr. McPherson

at *(enter receiving facility and unit name)* Vanderbilt.

Based on an assessment of this patient, emergent transportation is required for the following reasons (mark all that apply, minimum of one from both sections):

1 - REASON(S) FOR METHOD OF TRANSPORT:

☒ The patient's condition was **TIME CRITICAL**, requiring rapid air transportation in order to minimize morbidity / mortality.

☒ The patient's condition met established criteria for transport based on published standards for appropriate utilization of air transport from the EMS, cardiac, trauma, pediatric, and neonatal communities.

☒ During transport, the patient's condition required critical care life support and monitoring by an ALS crew with an attending RN present (*specify care*): ☐ Intubated ☐ TPA infusion ☐ IABP ☐ ETCO2 Monitoring ☐ EKG
☒ IV Medications, titrated drips (*specify Medications*) Dopamine gtt NS x2
☒ Ventilator dependent at the time of transport ☐ Other _____

☒ Ground transport would have been hazardous due to the **LENGTH OF TRANSPORT**. Ground transport time of _____ minutes versus air transport time of _____ minutes.

☐ Ground transport would have been hazardous and / or delayed due to: ☐ Rush hour / traffic conditions ☐ Bridge out / road construction ☐ Adverse weather conditions require fixed wing transport ☐ Care needed beyond the scope of a ground unit

2 - REASON(S) PATIENT REQUIRED TRANSPORT:

All Interfacility transports must document why the referring facility was not the appropriate facility

The referring facility, evidenced below and superseding any other documentation in electronic, paper or any other media format, was not the appropriate facility due to (*mark all that apply*):

☒ Define all services not available at the time of transport (required): Cardiology, ICU

☒ Bed or appropriate bed (e.g. ICU/CCU) for care was not available at the time of transport;

☒ Unequipped/ Specialty Service Department not open/ available to provide necessary hospital care at the time of transport;

☒ Appropriate physician or physician specialist not available to provide the necessary care required to treat the patient;

☐ Appropriate surgeon or back-up surgeon not available at the time of transport and or;

☒ Patient's condition at the time of transport requires a higher level of trauma care or other specialized care not currently available at the time of transport.

☐ Specialized **maternal / neonatal** care required with high-risk obstetrician and / or neonatal ICU **not available at referring facility.** Other maternal / neonatal specialized services needed *(describe care required and facilities needed)* _____

☐ Specialized Level I Trauma Care required with diagnostic and trauma surgical facilities readily available. *(Describe services not available at referring facility)* _____

Mechanism of injury: ☐ Fall > 20 feet ☐ MVC with rollover ☐ Pedestrian struck by motor vehicle ☐ MVC with ejection ☐ [illegible] ☐ Blast injury ☐ Extrication time > 30 minutes ☐ Trauma patient > 55 years of age or more proximal extremity fractures ☐ Pregnant trauma patient ☐ Crash speed change>20 mph

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_____ /PA/NP (or per voice order)

_____ Signature of Referring MD/DO/RN/PA/NP (or per voice order)

60904-6/14/10

Flight# _____

MR# _____

Vanderbilt LifeFlight Signature Form – Version 1.5

Patient Name: Pauta Cherry **Transport Date:** 5/31/11

I hereby authorize Vanderbilt University Medical Center, its agents, employees and/or physicians, to transport and for services provided to me by Vanderbilt LifeFlight now or in the future by means of the Vanderbilt LifeFlight Ground, Helicopter or Fixed Wing. I understand the risks, benefits and alternatives of this transfer. I further authorize the administration of such diagnostic procedures, medications and medical treatment as may be deemed necessary prior to or during transport in order to stabilize my/his/her medical condition.

In the event that I am unable to be present at the hospital upon arrival, I hereby consent to and authorize such hospital to provide care, diagnostic procedures and medical treatment, including testing for HIV antibodies (AIDS test), as may be deemed necessary by the attending physician.

I understand that expeditious transport to the Hospital has been determined to be medically necessary, and I hereby request and authorize that such transport be made by ground or air ambulance. I understand that I am financially responsible for the services provided to me by Vanderbilt LifeFlight, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Vanderbilt LifeFlight any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Vanderbilt LifeFlight. I authorize Vanderbilt LifeFlight to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Vanderbilt LifeFlight and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Vanderbilt LifeFlight, now or in the future. I understand that air ambulance is a more expensive mode of medical transport than is ground transportation.

I understand that a copy of the Vanderbilt LifeFlight Notice of Privacy Practices will be provided. If transferred to VUMC, the VUMC Notice of Privacy Practices will be provided as soon as reasonably practicable by mail or hand-delivery.

SIGNATURE SECTION:

ONE of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

This Section is for emergencies or non-emergencies.

The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____

Patient Signature or Mark Date

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. This can be an transport crew member.

X _____

Witness Signature Date

_____

Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

This section is for emergencies or non-emergencies.

Complete this section only if patient is physically or mentally incapable of signing. **Reason the patient is physically (unconscious/unresponsive, physical disability, the patient's condition is emergent in nature; such that any delay in treatment could reasonably result in catastrophic consequences; such as permanent disability and/or the loss of life or limb, etc) or mentally (experiencing an altered level of consciousness, language barrier during an emergent situation, without an immediate means of language translation available, known to be under the influence of alcohol/narcotics, mental disability, etc.) incapable of signing:

_____

Authorized representatives include only the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____ 5/31/11 Pauta Cherry

Representative Signature Date Printed Name of Representative

SECTION III - EMERGENCIES ONLY - TRANSPORT CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section only if all of the following are true: (1) the call is an emergency ambulance transport, (2) the pt was physically or mentally incapable of signing, and (3) no authorized representative (Section II) was available or willing to sign on behalf of the pt at time of service.

A. Transport Crew Member Statement (*must* be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____

Signature of Crewmember Date Printed Name of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

X _____ _____

Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B above cannot be obtained)

ure is obtained, the ambulance crew should attempt to obtain one or more of the following forms of ceiving facility indicating that the patient was transported to that facility by ambulance on the date and e of this information to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

representative of facility)

☐ Facility Face Sheet/Admissions Record
☐ Hospital Log or Other Similar Facility Record

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MACON COUNTY GENERAL HOSPITAL

204 Medical Drive Phone 666-2147 Lafayette, TN

Name: Pamela Cherry

Address: _____ Date: 05

℞ Valium 5mg
T.P.O. q 12 hr
Flexeril 10mg T.P.O. q 8 hr
#30

Label: ☐YES ☐NO
Age ____ Wt. ____
Refill 0-1-2-3-4-5 P.R.N.

_____ M.D. _____
Substitution OK Dispense As Written

DEA#: BT5961017